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Vol. 82, No. 1, January 6, 1983

Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

MSMS MEMBERS ACCOMPLISHED MUCH IN 1982

1982 saw MSMS members achieve many firsts for their association, reach goals set and strike out in new directions. Here is a partial list of what MSMS members did for each other in 1982:

1) Created the new Physicians Review Organization of Michigan to assure quality and appropriateness of medical care;
2) Topped the 10,000 member figure with the processing of the membership forms of Keith A. Miyamoto, MD, Cheboygan;
3) Implemented a low premium, high deductible, co-pay insurance plan for doctors, their families and their employees;
4) Increased the number of Michigan delegates and alternates to the AMA by two;
5) Provided 40 in-office practice management consultations for Michigan physicians;
6) Staged eight practice management seminars for new physicians and for those already established in practice;
7) Successfully fought clinical laboratory ownership legislation which would have prevented physicians from referring patients to laboratories in which the physicians had any interest;
8) Supported enactment of HB 5762 and SB 611 to curb provider abuse of the Medicaid program;
9) Oversaw implementation of the Physician Primary Sponsor Plan after it withstood a court challenge in Wayne County.
10) Started the Michigan Council for Graduate Medical Education.
11) Created a new Committee on Child Abuse;
12) Produced the new Michigan Guidelines for Regionalized Perinatal Care;
13) Chaired the Michigan Coalition for Safety Belt Use, and pledged continued public relations support and participation in the project for 1983-84;
14) Held the first MSMS Conference for women physicians and established a Committee on Concerns of Women Physicians;
15) Established a medical staff relations committee which sponsored two conferences in the spring and fall;
16) Supported the medical malpractice arbitration statute by filing an amicus curiae brief with the state supreme court;
17) Developed a five-point legislative package to improve the professional liability climate in Michigan;
18) Launched "Challenge of the 80s" medical practice guide.
19) For the second year in a row, did not raise dues.

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MSMS COMMITTEE ON HEALTH PLANNING REORGANIZING

An executive committee of the MSMS Steering Committee on Heal Planning will meet Jan. 12 at MSMS headquarters to reorganize to meet state-level, rather than federal-level, health manpower planning issues expected to demand action from the committee soon. The committee also will discuss a response to the Office of Health and Medical Affairs request for MSMS proposals to improve physician distribution in Michigan. The OHMA has requested MSMS ideas in place of proposals for a health service corps already advanced by OHMA but disapproved by MSMS.

MSMS AWAITS NEWS OF PUBLIC HEALTH DIRECTOR APPOINTEE

Lansing's big news this week in MSMS opinion was the appointment of key government leaders in the administration of new Governor James Blanchard. The Governor retained Department of Mental Health Director C. Patrick Babcock from the Milliken administration. Mr. Babcock formerly was director of the Michigan Department of Labor and of the Office of Substance Abuse Services. He has worked closely with MSMS as acting and then full director of the DMH in the year since he was appointed to replace former director Frank Ochberg, MD.

Other key appointments include Sister Agnes M. Mansour, president of Mercy College of Detroit since 1971, to replace Noble Kheder as director of the giant Michigan Department of Social Services. Noble Kheder had served just since the death in April of longtime DSS Director John Dempsey, PhD. Replacing Department of Licensing and Regulations Director Silverenia O. Kanoyton will be Elizabeth P. Howe, an MSU trustee and communications director of the Blanchard campaign. Ms. Howe is general manager of United Nederlander Cable Co. in Birmingham. S. Martin Taylor replaces William Long as labor director, and Ralph J. Gerson becomes commerce director and counselor to the governor, replacing Norton Berman.

Governor Blanchard's appointment to director of the Michigan Department of Public Health was not revealed at this writing. Current MDPH director Bailus Walker, PhD, was to serve until the appointment was firmed.

CAPSULES

Three MSMS representatives are in Florida as this Medigram is written, attending the annual AMA Conference on State Health Legislation. They are Frederick V. Minkow, MD, Bloomfield Hills orthopedic surgeon and member of the MSMS Committee on State Legislation and Regulations; and Bruce Ambrose and Sherry Wellman of the MSMS staff....ATTENTION MSMS DELEGATES: Dates for the 1983 MSMS House of Delegates meeting are April 29–May 1. Place of the meeting will be the Hyatt Regency Dearborn. Details are available from Richard Campau at MSMS headquarters. ...Jan. 10 is the deadline for the first 1983 dues payment for those MSMS members who chose the new installment plan. Wayne Burmeister at MSMS headquarters has the details.

MEDIGRAM

Michigan State Medical Society
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East Lansing, Michigan 48823

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Vol. 82, No. 1, January 6, 1983

Vol. 82, No. 2, January 13, 1983

Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

MSMS READYING FIVE-PART MALPRACTICE LEGISLATIVE PACKAGE

MSMS is preparing to launch a five-part legislative package designed to improve the malpractice liability situation for Michigan physicians. Specifically, the MSMS effort will be to clarify and circumscribe procedures for determining physician liability in claims of professional malpractice. Leading the legislative effort will be the MSMS Committee on Professional Liability, chaired by Frederick V. Minkow, MD, Bloomfield Hills.

LIBRARY

MSMS plans to have the bills introduced this month by concerned lawmakers. When the bills come up for discussion in committees, probably in March, MSMS will be ready with a 24-page explanatory booklet for each legislator describing MSMS concern with the high costs of medical care, MSMS programs to contain those costs, and the important role MSMS sees for the malpractice legislation in this cost-containment effort.

Adoption of the five MSMS proposals into state law will:
1) Permit the court's consideration of collateral source payments, such as health insurance, received by the plaintiff as the result of the incident on which the claim is based;
2) Assure minimum qualifications of expert witnesses;
3) Establish degree of fault ("comparative negligence") for which a defendant can be held liable in cases with multiple defendants;
4) Place reasonable limits on awards to compensate for pain, suffering, inconvenience, physical impairment and other non-economic losses;
5) Permit payment of certain damages in whole or in part by periodic payments rather than lump-sum amounts.
The MSMS legislative package and its goals will be described in greater detail in the March issue of Michigan Medicine.

MSMS AWAITS SUPREME COURT ACTION ON MALPRACTICE ISSUES

MSMS is awaiting further action on two issues before the Supreme Court of Michigan. MSMS has supplied, on request, its suggested language for a new rule which would allow judges to award court costs in malpractice suits deemed unmeritorious. This issue has been pending for over a year, since the MSMS Council called for action to minimize frivolous suits.

In the second issue, MSMS is awaiting a decision by the high court in a suit supported by MSMS and the Wayne County Medical Society by an amicus curiae brief. The joint MSMS-WCMS brief supports the Michigan Medical Arbitration System in the two cases before the Supreme Court questioning the constitutionality of the system.

Inside: Your 1983 CME Record-keeping Folder

MSMS, ANESTHESIOLOGISTS PLANNING FEB. 19 NEGOTIATIONS WORKSHOP

A one-day seminar in negotiating contracts is being planned for the state's anesthesiologists as a joint project of MSMS and the Michigan Society of Anesthesiologists. The seminar is scheduled Feb. 19 at the Marriott Inn in Ann Arbor. It will feature lecture, film and role-playing sessions, with a mock negotiation meeting as the highlight of the day's sessions. In addition, there will be reviews of the new tax laws' impact upon professional corporations, and of the new Medicare regulations upon anesthesiology practices. Key speaker will be Jerry P. Clousson, JD, LLM, former director of the AMA Department of Negotiations, national expert in training physicians on the art of negotiation and the subtleties of compromise. Planning chairman for the meeting is Gary D. Maynard, MD, Kalamazoo. Registration details are available from William Madigan at MSMS headquarters.

MSMS COMMITTEES HARD AT WORK IN 1983

The MSMS calendar is crowded as the new year's schedule accelerates. Following is a list of coming meetings. Unless otherwise indicated, all are at MSMS headquarters.

Jan. 19--MSMS Council
Jan. 19--Committee on CME Planning, Holiday Inn, Howell
Jan. 19--Committee on Humanitarian Services
Jan. 19--MDPAC Board of Directors
Jan. 20--Committee on Concerns of Women Physicians
Jan. 26--Steering Committee on Program to Assist Impaired Physicians
Jan. 26--Professional Review Organization of Michigan
Feb. 2--Advisory Committee to Bureau of Economics
Feb. 2--Committee on Professional Liability
Feb. 2--Judicial Commission
Feb. 2--Committee on State Legislation and Regulations
Feb. 9--Planning Committee, 1983 MSMS Annual Scientific Meeting
Feb. 10--CME Accreditation Committee
Feb. 16--Liaison Committee with Michigan Department of Public Health

PSG EXPANDING ADMINISTRATIVE SERVICES TO GROUPS

The MSMS Physician Service Group, Inc. (PSG), is expanding its administrative services to medical groups. Michigan physicians may give PSG the names of any organizations which would benefit from the PSG's services, including staffing for meetings, dues collection, dissemination of information and records storage. PSG currently contracts administrative services for the Michigan Association for Medical Education; Michigan Chapter, American College of Surgeons; Michigan Society of Anesthesiologists; Michigan Society of General Surgeons; Michigan Society of Respiratory Therapists; MSMS Auxiliary, and the State of Michigan Branch, American Association of Medical Assistants. For details, contact John Anthony at MSMS headquarters.

Supplement to Michigan Medicine/Medigram

MSMS physician's CME record-keeping folder

Detach and Retain as a File Folder

MSMS, in cooperation with the Michigan Board of Medicine, developed this Medigram section to help physicians understand state CME rules and to keep their records of attendance.

How often must I report my compliance with CME rules?	Every three years you must register and certify compliance by signing the CME part of your re-registration card.
Must I renew my license before 1984?	If you are among the one third of physicians who must do so, you should receive a renewal application from the Michigan Department of Licensing and Regulation about Nov. 1.
If I expected a renewal certificate card this fall, but did not receive it?	First check your records--you must have renewed your license and paid your fees for three years in December 1981 or 1980.
What does compliance require beyond earning CME hours?	Keeping evidence of compliance for four years and being ready for a board audit. (see copy of statement below)
What kind of evidence will be sufficient for the auditors?	Certificates of attendance, receipts, cancelled checks--the same type of proofs asked by the Internal Revenue Service.
How important is the evidence?	Failure to provide it shall be deemed to establish a rebuttal presumption that the licensee made a false or fraudulent statement in applying for a license.
But don't the sponsors keep records of their CME activities?	Yes, but only to substantiate your claims of participation. As with IRS data, it's your responsibility to keep records.
How should I keep the evidence?	Carefully organized year by year in a folder like this.
What is the CME year?	February 1 - January 31.
I understand that specialty board certification or recertification earns me 50 hours of Category I credit. But when does it apply?	You have to report your certification or recertification in the year you are notified, and it applies in that year.
May I earn credit by attending an out-of-state meeting?	Michigan makes no distinction regarding out-of-state courses. Michigan accepts the credits that make up the Physician's Recognition Award of the AMA.
Who can help me with questions about my CME compliance?	Check this folder's information on categories and requirements and/or contact the Michigan Board of Medicine, 905 Southland, P.O. Box 30018, Lansing, MI 48909; telephone 517/373-0680.

HERE'S WHAT YOU CERTIFY WHEN YOU SIGN COMPLIANCE FORM

I hereby certify that I have earned 150 hours of Continuing Medical Education in the preceding 3 years (1980-81-82), including a minimum of 75 hours in Category 1; or 100 hours of Continuing Medical Education in the preceding 2 years if originally licensed in Michigan in 1981, or 50 hours of Continuing Medical Education in the past year if originally licensed in Michigan in 1982. I understand that it is my responsibility to maintain evidence of my compliance with the CME requirements, that this evidence must be kept for a period of 4 years and that I am subject to an audit of all such evidence. I acknowledge that the Michigan Board of Medicine considers this a part of my application for renewal of medical licensure.

Retain this folder to record activities and to hold CME programs, notes, receipts

Category 1

Activities with accredited sponsorship; tutorial experience; medical ethics; specialty board certification/recertification

1981 cr.hrs. ____

1982 cr.hrs. ____

Minimum credit hours (clock hours) in three years: 75; maximum, 150.

ACTIVITY ________________ Date ______ cr.hrs.____/____
Sponsor ________________ Location ______________

ACTIVITY ________________ Date ______ cr.hrs.____/____
Sponsor ________________ Location ______________

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ACTIVITY ________________ Date ______ cr.hrs.____/____
Sponsor ________________ Location ______________

Category 2

Activities with nonaccredited sponsorship 1981 cr.hrs. ____

Maximum credit hours (clock hours) in three years: 36. 1982 cr.hrs. ____

ACTIVITY ____________ Date ______ cr.hrs. _____/_____

Sponsor ____________ Location ____________

ACTIVITY ____________ Date ______ cr.hrs. _____/_____

Sponsor ____________ Location ____________

ACTIVITY ____________ Date ______ cr.hrs. _____/_____

Sponsor ____________ Location ____________

Category 3

Teaching physicians or allied health services 1981 cr.hrs. ____

Maximum credit hours (two per clock hour) in three years: 48. 1982 cr.hrs. ____

ACTIVITY ____________ Audience ____________ cr.hrs. _____/_____

Sponsor ____________ Location ____________ Date ______

ACTIVITY ____________ Audience ____________ cr.hrs. _____/_____

Sponsor ____________ Location ____________ Date ______

ACTIVITY ____________ Audience ____________ cr.hrs. _____/_____

Sponsor ____________ Location ____________ Date ______

Category 4

Books, papers, publications, and exhibits 1981 cr.hrs. ____

Maximum credit hours (clock hours) in three years: 48. 1982 cr.hrs. ____

ACTIVITY ____________ Date ______ cr.hrs. _____/_____

Event and place
Publication or publisher ____________

ACTIVITY ____________ Date ______ cr.hrs. _____/_____

Event and place
Publication or publisher ____________

ACTIVITY ____________ Date ______ cr.hrs. _____/_____

Event and place
Publication or publisher ____________

Category 5

Nonsupervised education — 1981 cr.hrs. ____

Maximum credit hours (clock hours) in three years: 36. — 1982 cr.hrs. ____

Self-assessment (Maximum credit hours: 18)
Self-instruction (Maximum credit hours: 18)
Quality care or utilization review (Maximum credit hours: 18)

ACTIVITY ______________________________ cr.hrs._____/_____

ACTIVITY ______________________________ cr.hrs._____/_____

ACTIVITY ______________________________ cr.hrs._____/_____

Category 6

Full-time participation in graduate training program of at least five full months — 1981 cr.hrs. ____

1982 cr.hrs. ____

Maximum credit hours: 50 per year.

PROGRAM SITE ______________________________

Program dates _________

CONTINUING MEDICAL EDUCATION RULES INFORMATION

All requests for complete copies of the revised CME rules for Michigan licensees and additional information should be directed to:

Michigan Board of Medicine
905 Southland
P.O. Box 30018
Lansing, Michigan 48909

Telephone 517/373-0680

The board may deny a request for approval of activities for CME credit whenever it appears that the request fails to demonstrate compliance with the legislative intent to further educate licensees on subjects related to the practice of medicine.

SUMMARY OF CME CREDIT

	1981	1982	1983
Category 1	______	______	______
Category 2	______	______	______
Category 3	______	______	______
Category 4	______	______	______
Category 5	______	______	______
Category 6	______	______	______
TOTALS	______	______	______

Additional copies of this folder may be obtained, free of charge, from the Michigan State Medical Society, 120 W. Saginaw Street, East Lansing, MI 48823 (517/337-1351)

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CHALLENGE OF 80s ORDER FORM IN JANUARY MM

The January issue of Michigan Medicine will offer MSMS members the opportunity to order their copies of the forthcoming MSMS manual, "Meeting the challenge of the 80's." The manual cover will be bound inside the magazine with an order form. Anticipated delivery is around the end of February.

The manuals will be distributed to all participants in a series of six to eight one-day workshops planned by MSMS around the state beginning in early March. The workshops will cover the same major topics of the manual's sections: competition, communication, practice management, and ethics. They will be presented by a team of MSMS staff and outside experts, with the emphasis on the practical. An abbreviated workshop is anticipated for county medical society meetings by the fall.

MSMS SETS MEMBERSHIP RECORDS

MSMS membership figures were over the 10,000 mark at the close of 1982. As of Dec. 31, MSMS had 10,086 members, 8,439 of them active members, and the remainder in the dues-exempt category, which includes life and retired members. Close to 575 new member applications were processed by the MSMS office in 1982. The net gain after adjustments for attrition was 130 members over 1981. MSMS now has 108 student members, twice the number of a year ago, and 38 new resident members. Because of the gain in AMA members, the Michigan delegation to the AMA added two seats.

OFFICE PHYSICIANS HIRING MORE NON-MD PERSONNEL

The AMA Socioeconomic Monitoring System reports there has been a dramatic increase in the number and kinds of non-physician personnel employed by physicians in their practices. The increase in allied health professionals has been especially large. The average office-based practice employs nearly three times the number of non-physician personnel as it did in 1975. This includes an almost five-fold increase in the number of allied health professionals, from .47 per practice in 1975 to 2.25 in 1981. This reflects that physicians' practices are able to increase their productivity by assigning appropriate ancillary tasks to these personnel.

'BUCKLE UP--- YOUR DOCTOR CARES'

You can promote seat belts, Doctor, by buying and wearing the attractive blue and white buttons shown at left. MSMS is making the buttons available to MSMS members at cost for distribution to patients, family and friends. MSMS is developing bumper stickers for public distribution as well, as part of a continuing effort to encourage seat belt usage. The buttons may be ordered below for $27/hundred (must be ordered in 100 lots).

_______YES, I wish to support seat belt usage. Please send me ______ "Buckle up" buttons. (Please order in multiples of 100.)

My check for $_______ is enclosed ($27 x lots of 100)

Name____

Address____

MSMS EXPANDS GROUP COVERAGE FOR SUBSTANCE ABUSE

Limited substance abuse treatment in outpatient settings now is a covered benefit of the MSMS group health insurance plans, following passage of new acts. PA 232 and PA 233, effective Jan. 1, require Blue Cross and Blue Shield of Michigan to include benefits for outpatient treatment of substance abuse (alcoholism and drug addiction) in all BCBSM underwritten group contracts. There is a limit, however, to the amount that will be paid by BCBSM, depending on the terms of the group's contract. MSMS group health plans already cover inpatient substance abuse treatment in BCBSM-participating hospitals for a limited number of days. MSMS members may contact Wayne Burmeister at MSMS headquarters for details.

DON'T EXCLUDE YOURSELF FROM WORKERS' COMP COVERAGE

Some Michigan physicians may have created a serious gap in their personal medical coverage, says the Michigan Physicians Mutual Insurance Company. They may have excluded themselves from workers' compensation benefits, says MPMLC. An amendment to the Michigan Workers' Compensation Act which became effective Jan. 1 allows exemption of eligible employees of a corporation under certain circumstances. Section 418.161 of the act provides that an employee of a corporation with no more than 10 stockholders who also is an officer and stockholder owning at least 10 percent of the company's stock may elect to exclude himself or herself from coverage.

Those physicians who have thus excluded themselves from workers' comp benefits probably have acted with the belief that their medical coverage would adequately protect them in the event of a work-related disease or injury. But such is not the case, says MPMLC. Blue Cross and Blue Shield have analyzed the act and reported the following position:

"The corporate position is to retain our current policy of not providing benefits for any services necessitated by a job-related injury. This applies regardless as to the employees' eligibility status under the employer's workers compensation plan."

Further information is available from the Marketing Department of MPMLC.

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Vol. 82, No. 2, January 13, 1983

MICHIGAN MEDICINE

January 1983 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Volume 82, Number 3

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Keeping courtrooms empty

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AMA Delegation	Bruce Ambrose, Wayne Burmeister
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Program	Sherry Fent
Meeting Facilities	Linda Munson
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Continuing Medical Education	
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Michigan Society of General Surgeons	Caroline Rich
Michigan Society of Respiratory Therapists	Caroline Rich
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MSMS Travel Programs	Donna Farougi
Physician Hospital Relations	William Madigan
Physician Legislative Network	Kevin Kelly
Physician Service Group	John Anthony
Practice Management Seminars	John Anthony
Professional Liability Insurance	William Madigan
PSRO	Sherry Wellman
Specialty Societies	
Information	Nancy Wimmer
Committee of Specialty Society Presidents	William Madigan
Third Party Payors	John Richards

MSMS ADDRESS: Michigan State Medical Society
120 West Saginaw (Box 950)
East Lansing, MI 48823

MSMS PHONE: 517/337-1351

Challenge of the 80's

A guide to successful medical practice

Prepared by Michigan State Medical Society

Whom to call at MSMS headquarters

You're seeing the cover . . .

Why not order the whole thing?

Having cash flow problems? Patient visits down? Have a question about some legal or ethical aspect of the practice? Want to do a better job of communicating with patients? Worried about competition from that HMO or freestanding urgent care center?

If your answer to any of the above questions is "YES," then you will want to order a copy of "Challenge of the 80s— A guide to successful medical practice." This new MSMS book addresses questions like these and more as it offers practical help on practice management, legal-ethical issues, communications, and competition. You've seen some of the segments in *Michigan Medicine* since last March, but there's much more— some 100 pages worth! It will be available in late February to MSMS members. You can reserve your copy now by completing the form below and returning it to MSMS with your check.

Your order placed now will enable us to print a sufficient quantity to meet the need and demand. The cost is $5 per copy for members and $15 per copy for non-members and non-MDs.

☐ Yes, I'm an MSMS member. Reserve my copy of "Challenge of the 80s." Enclosed is my check for $ ______ for ______ copy(ies) of same.

☐ I'm not a member, but I'd like to order ______ copy(ies) at $15 each. My check is enclosed.

Name ______________________________
(Please Print)

Mailing Address ______________________________
____
____

(Orders will be filled around Jan. 30.)

MICHIGAN MEDICINE
Keeping courtrooms empty

MICHIGAN MEDICINE

January 1983, Vol. 82, No. 3

Special report

2 The numbers of lawsuits alleging medical malpractice are rising geometrically. The size of settlements is increasing to astronomical levels. It is a frightening situation for the Michigan physician, and MSMS knows it. Your state medical society is working on a major malpractice legislative package to help ease some of the strain. MSMS also has developed an extensive presentation on good medical record-keeping practices to minimize physicians' risk. The outline of that presentation is published here; Louis R. Zako, MD

Features

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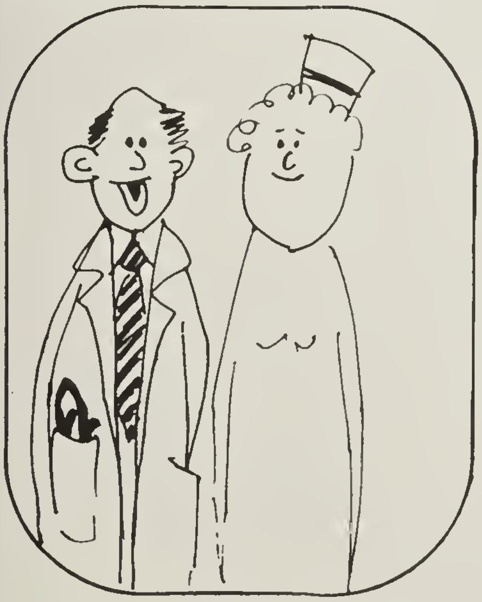
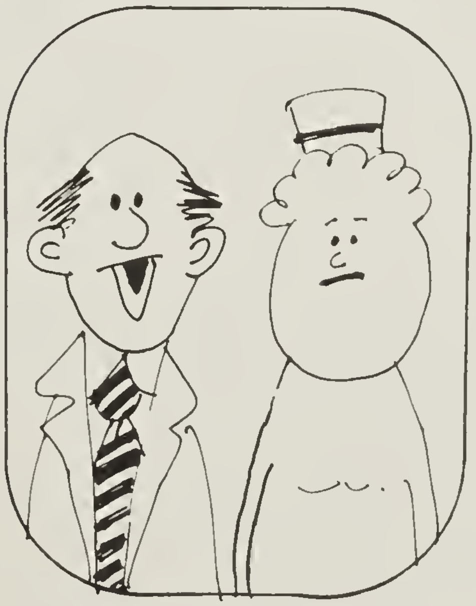
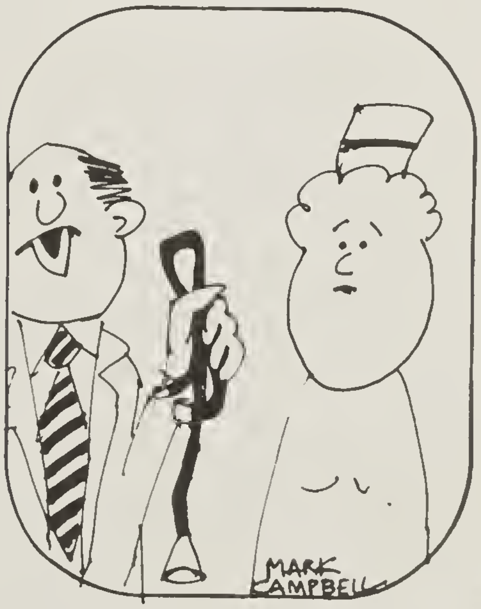
Doctor Quickdraw



I have practiced good medicine for over 20 years without a law suit.



I knew that the malpractice problem had worsened, and I worried that someday I might be sued.



. . . But I never would have expected this malpractice case alleging my stethoscope was too cold.

SPECIAL REPORT

MSMS risk management help zeroes in on medical records

Louis R. Zako, MD
Dearborn Heights

The MSMS Committee on Risk Management wishes to inform Michigan physicians of a newly-developed outline addressing the risk management prevention issue of maintaining proper medical records.

The Committee, with the help of consultants and MSMS staff, has developed a one-and-a-half hour teaching outline to be used by MSMS and its sponsored insurance carrier, the Michigan Physicians Mutual Liability Company (MPMLC). Robert M. Leitch, MD, president of MPMLC, and I will present this medical records course to residents and medical staffs who attend the MSMS and MPMLC practice management and risk management programs.

At malpractice seminars for plaintiff attorneys, the patient's medical chart is a prominent item on the agenda. Attorneys scrutinize medical records for discrepancies, omissions or alterations with the intent to impeach the defendant doctor's testimony and weaken his credibility. Good medical records can be the strongest force in the defense of a malpractice case. The outline in this issue's special report provides you with the needed ingredients to insure that you are documenting your records properly. Be sure to clip this article out and share with your office staff. We're confident that all of your employees will benefit from this presentation. **(The article begins on page 6.)**

The MSMS Risk Management Committee also has met with the Michigan Physicians Mutual Liability Company (MPMLC) and the Physicians Insurance Company of Michigan (PICOM) representatives to initiate a pilot study in identifying malpractice complaints within the specialty of obstetrics and gynecology. Bruce Drukker, MD, president of the Michigan Section of the American College of Obstetricians and Gynecologists, is among the design group initiating this study. The proposal includes selecting 50 policy-holders from each insurance company who are members of the Michigan Section of the American College of Obstetricians and Gynecologists. Twenty-five from each company will receive risk management counseling on how to avoid specific ob/gyn incidents, while the remaining 25 insureds of each company will be informed about risk management principles as are any other policy-holders of the respective companies, i.e., they will receive no special training on the avoidance of suits. MSMS plans to study these groups for a five year period to determine the effects of the specifics of the ob/gyn risk management program. It will work with MPMLC and PICOM actuaries to develop the probabilities of a reporting and follow up system. As MSMS learns more from this project, it surely will be applying this experience to other specialties.

Members of the committee are Peter McCabe, MD; Leland E. Holly, II, MD; Robert M. Leitch, MD; Marguerite Shearer, MD; Douglas Peters and Karen Sowislo, consultants.

Doctor Zako is chairman of the MSMS Committee on Risk Management.

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Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

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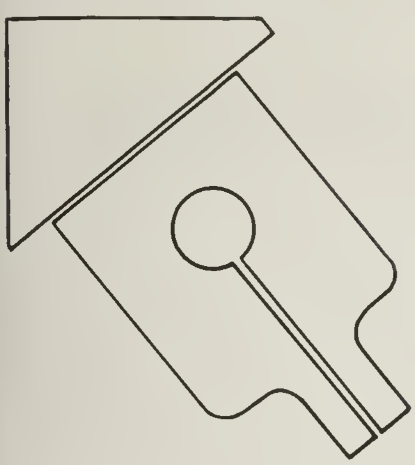
LETTERS



Tylenol thanks

We want to thank the thousands of health care professionals who have written or called us expressing their confidence and trust in our company and in the quality of our products. Your support over the years has played a major role in the success of our company and of our products. Now, we must ask for your support again.

As a member of the Johnson & Johnson Family of Companies and employees of McNeil Consumer Products Company, we are deeply saddened and outraged by the senseless killing of innocent people. No expression of sympathy or concern adequately conveys our feelings for the victims and their families. The tragic events in the Chicago area have damaged our entire society. The public's confidence and trust in the medicines you recommend and prescribe have been undermined.

Without wanting to downplay the seriousness of the seven deaths in the Chicago area, we strongly believe these incidents must not be allowed to shake public confidence. If we were to abandon the TYLENOL® brand name or if we were to fail to restore public confidence in TYLENOL, we would be yielding to a new form of economic terrorism. We are determined that this will not happen.

Due to the manner in which the story unfolded, members of your association and their patients may be seeking assurance from you in separating rumor from fact. The following are the significant facts:

- Only Extra-Strength TYLENOL capsule products were maliciously adulterated. No other TYLENOL products have been implicated.
- The tragic events were limited to the Chicago area.
- Isolated incidents reported outside of the Chicago area were found to be unrelated to the cyanide tampering with Extra-Strength TYLENOL capsules.
- The tamperings did not take place at a McNeil facility. After a thorough investigation by the FDA, they have exonerated McNeil. All evidence indicates that the adulterations took place at the retail level.

While recent surveys show that many consumers are aware of the details of the poisoning incidents, many acknowledge residual fears about the product. Bertram Russell once stated, "To conquer fear is the beginning of wisdom." Will you join with us in that beginning?

Together we can restore the confidence of the public and of your members and their patients, not only in TYLENOL but in all the medicines they use and rely on.

Thomas N. Gates, MD
Medical Director
McNeil Consumer
Products Company
Camp Hill Road
Washington, PA 19034

Nuclear war

As a follow up to Dr. Fryfogle's article about the conflicts of nuclear war, I came upon this interesting report from *Readers Digest.*

"In October of 1981, Denmark arrested Arne Peterson, sponsor of the Oslo-to-Paris Peace March as a Soviet agent. Peterson had met with KGB officials on 23 occasions. Yuri Kaprolov, a KGB officer sat on a discussion panel of the first meeting of the American Nuclear Freeze Campaign at Georgetown in March of 1981. That same month, the International Physicians for the Prevention of Nuclear War held a meeting in Virginia. Georgie Arbitov, ostensibly a socialist, made a speech that was greeted with thunderous applause. He heads the Institute for the U.S.A. and Canada.

The message is that physicians must be very careful that they are not being used or manipulated.

Joseph Arends, MD
Troy

Columbia III

Thank you for sending the issue of *Michigan Medicine* with the article about space medicine. I thought it was very well done and accurate. I hope you received a positive response on this article from your readers.

Collecting the data for this article, in what remains as a unique environment, was a most rewarding and challenging experience! To see it properly presented, as you managed to do, was most gratifying.

Thanks again!

Sincerely,
Jack Lousma
NASA
Houston, TX

Candidates for nutritional therapy...

10,000,000 alcoholics. Ethanol may produce many effects that together bring about nutritional deficiencies, so that alcoholism affects nutrition at many levels.[1]

25,500,000 geriatric patients. The older patient may have some disorder or socio-economic problem that can undermine good nutrition.[2]

23,500,000 surgical patients. Nutritional status can be compromised by the trauma of surgery; and some operations interfere with the ingestion, digestion and absorption of food.[3]

Before prescribing, please consult complete product information, a summary of which follows:
Each Berocca® Plus tablet contains 5000 IU vitamin A (as vitamin A acetate), 30 IU vitamin E (as *dl*-alpha tocopheryl acetate), 500 mg vitamin C (ascorbic acid), 20 mg vitamin B_1 (as thiamine mononitrate), 20 mg vitamin B_2 (riboflavin), 100 mg niacin (as niacinamide), 25 mg vitamin B_6 (as pyridoxine HCl), 0.15 mg biotin, 25 mg pantothenic acid (as calcium pantothenate), 0.8 mg folic acid, 50 mcg vitamin B_{12} (cyanocobalamin), 27 mg iron (as ferrous fumarate), 0.1 mg chromium (as chromium nitrate), 50 mg magnesium (as magnesium oxide), 5 mg manganese (as manganese dioxide), 3 mg copper (as cupric oxide), 22.5 mg zinc (as zinc oxide).

Indications: Prophylactic or therapeutic nutritional supplementation in physiologically stressful conditions, including conditions causing depletion, or reduced absorption or bioavailability of essential vitamins and minerals; certain conditions resulting from severe B-vitamin or ascorbic acid deficiency; or conditions resulting in increased needs for essential vitamins and minerals.

Contraindications: Hypersensitivity to any component.

Warnings: Not for pernicious anemia or other megaloblastic anemias where vitamin B_{12} is deficient. Neurologic involvement may develop or progress, despite temporary remission of anemia, in patients with vitamin B_{12} deficiency who receive supplemental folic acid and who are inadequately treated with B_{12}.

Precautions: *General:* Certain conditions may require additional nutritional supplementation. During pregnancy, supplementation with vitamin D and calcium may be required. Not intended for treatment of severe specific deficiencies. *Information for the Patient:* Toxic reactions have been reported with injudicious use of certain vitamins and minerals. Urge patients to follow specific dosage instructions. Keep out of reach of children. *Drug and Treatment Interactions:* As little as 5 mg pyridoxine daily can decrease the efficacy of levodopa in the treatment of parkinsonism. Not recommended for patients undergoing such therapy.

Adverse Reactions: Adverse reactions have been reported with specific vitamins and

ROCHE®

5,000,000 hospital patients with infections.[4] Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.[3]

The incalculable millions on calorie-reduced diets. Patients ingesting 1000 or fewer calories per day could be at high risk because this intake may not supply most nutrients in adequate amounts without supplementation.[5]

Berocca Plus
A balanced formula for prophylactic or therapeutic nutritional supplementation.

Berocca Plus Tablets provide: therapeutic levels of ascorbic acid and B-complex vitamins; supplemental levels of biotin, vitamins A and E, and five important minerals (iron, chromium, manganese, copper and zinc); plus magnesium. Berocca Plus is not intended for the treatment of specific vitamin and/or mineral deficiencies.

Berocca Plus,
highly acceptable to patients, has virtually no odor or aftertaste and is economical. And its "Rx only" status means more physician involvement, better patient compliance.

References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease, op. cit.*, p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease, op. cit.*, pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med 89* (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

minerals, but generally at levels substantially higher than those in Berocca Plus. However, allergic and idiosyncratic reactions are possible at lower levels. Iron, even at the usual recommended levels, has been associated with gastrointestinal intolerance in some patients.

Dosage and Administration: Usual adult dosage: one tablet daily. Not recommended for children. Available on prescription only.

How Supplied: Golden yellow, capsule-shaped tablets—bottles of 100.

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Nutley, New Jersey 07110

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Rx ONLY **Berocca® Plus** TABLETS

THE MULTIVITAMIN/MINERAL FORMULATION

Good medical records can be strongest malpractice defense

Following is the outline of the pertinent, to the point course on good medical records keeping from the new MSMS risk management course for Michigan physicians.

Medical liability experts estimate that 35 to 40 percent of all medical malpractice suits are rendered indefensible by problems with the medical record. A bad result added to a bad record equals liability, regardless of the facts and regardless of the standard of care practiced.

The significance of medical records, both in the office and in the hospital, can be appreciated when one realizes that medical malpractice suits may come to trial anywhere from two to 10 years after the incident in question. At that point the physician will have little independent memory of contact with any single patient. The medical record therefore becomes invaluable to the defense because memory alone is worthless.

In addition, the medical record should reflect the complexity of a difficult clinical problem. If it does, it will demonstrate to a court that proper professional attention has been given to the medical problem. The law does not ask much more.

Mechanically, the record should be carefully prepared, complete, accurate, legible, germane, relevant, timely and generously informative.

Basic principles

A. All entries should be neat, legible and in ink.

B. Never erase — draw a single line through the incorrect entry, write the word 'error' above. If the error is noted at a later time, make a marginal note as to the data and time of the correction.

C. Use only hospital approved abbreviations and symbols — do not use ditto marks or initials.

D. Do not skip lines or leave blank spaces. Do not squeeze in extra words on a line. Draw a line through the empty space at the end of an entry.

E. Sign each entry (first and last name, professional designation).

F. Date and time each entry.

G. Date each page.

H. Use a supplemental page if necessary to record missed notes and indicate as a late entry.

I. Patient's name should appear on every page.

Medical records should include:

A. Names and signatures of nurses and physicians.

B. Notations of the patient's condition on admission and complete professional nursing assessment.

C. Progress notes on changes in conditions, both positive and negative.

D. Accounts of unusual incidents or injuries sustained while in the hospital.

E. Records of insertion and removal of drains and radium.

F. Patient's response to care and treatment, including refusal to cooperate or follow prescribed plan of care.

G. Patient's degree of mobility, appetite, orientation, mental attitude, and degree of independence.

H. Medications, treatments, vital signs, specimens obtained and where sent.

I. Visits of physicians, consultants and specialists, and contacts with, or attempts to contact, physician.

J. Informed consent for surgery and special procedures.

K. Deathbed statements of patient.

L. Accountability of patient's private property.

M. Teaching of patient or family, including instructions, medications and dietary rules.

Objective versus subjective

Use objective rather than subjective, observations and language. Do not use the term "apparently," or "It appears that . . . " State facts, not conclusions.

State specifically what you:

1. *See* — bleeding; pallor; deformities; type of drainage; color of urine.

2. *Hear* — the patient's complaints; moaning; stertorous breathing.

3. *Smell* — alcohol on the patient's breath; malodorous drainage; fecal odor in vomitus; acetone breath.

4. *Feel* — motion at a fracture site; crepitus of subcutaneous emphysema; a firm, hot area of induration.

5. *Do* for the patient, and what the response to treatment is — whether cervical traction relieves the neck pain or makes it worse.

6. *Do* to protect the patient — put the side rails up and lock them in place; put soft restraints on; help to ambulate when patient is unable to walk alone.

Problem items

A. Use of vague phrases such as "better, fair, c/o pain."

B. Meaningless charting, such as "linen changed."

C. Failure to record observations and follow-through steps, when vital signs are abnormal.

D. Failure to record patient's tolerance, response and outcome to medications and treatment.

E. State facts, not conclusions. If a patient is found on the floor, document that fact. If a patient says, "I got up, lost my balance, and fell," document that quotation. Do not say, "Patient apparently fell."

F. Do not enter "an incident report has been filled out" in a patient's medical record. Only objective information on patient care should be included in the medical record. Incident reports are designed to alert hospital personnel to problem areas and potentially dangerous trends so that corrective action can be taken.

G. Do not joust in the medical record. Avoid a criticism, complaining or arguing with another professional or department.

Injections and IV's

A. Record time and site of intramuscular, subcutaneous, intradermal and intravenous injections.

B. Site of infusion and appearance.

C. Type and size of needle.

D. Type and amount of fluid; medications added; rate administered.

E. Note conditions of the site and number of drops per minute on each shift.

Medications

A. Note the type of medications given, and time and route by which medication is administered.

B. If medication requires taking vital signs, medications nurse should take signs and chart them personally.

C. If for pain, note the site of the pain, and its severity.

D. If relief from pain is obtained, state when.

Operating room records should include:

A. Patient identification, level of consciousness and understanding of anticipated procedure.

B. Verification of allergies, NPO status and physical limitations, if any.

C. Condition of skin and skin preparation.

D. Patient suport mechanism and position.

E. Identification of prosthetic implants, medical devices, wound drains, catheters, packing, medical equipment and their location. Serial numbers and lot numbers should be included where applicable.

F. Sponge, needle and instrument count verification.

G. Output summary.

H. Specimen disposition.

I. Identification of type and location of patient monitoring device.

J. Location of electrosurgical grounding equipment.

K. Condition of patient upon transfer to post-receiving area and time.

L. Anesthesiologist's record.

M. Surgeon's operative note.

N. Pre-operative checklist.

O. Authorized observers in OR.

P. X-rays taken.

Q. Consent forms.

R. Post OP vist.

S. Consent should be signed and witnessed before preop. meds. given (date and time).

Discharge instructions should include:

A. Diet, either by the dietician or with the nursing staff.

B. Activity, such as restrictions on activity, importance of rest periods, exercise programs. Restrictive lifting should be documented.

C. Medications, with the name of medication, reason for taking dosage and frequency and side effects.

D. Skin care and hygiene.

E. Specific treatments, such as colostomy care, Foley catheter care, dressing changes.

F. Follow-up appointments, such as clinic appointment with physician, appointment with physical or occupational therapist.

G. Appropriate agency referrals, such as social services.

H. Record and document:

1. Patient and family's comprehension of instructions given.

2. Patient's ability to give a return demonstration of a procedure taught.

3. Booklets or written instruction sheets given to patient.

4. Completed transfer forms, if patient is transferred to an extended care facility.

5. Signed copies of instructions are helpful.

Documentation Guidelines

Michigan statute-MCLA 600.-2146 states, "Any writing or record whether in the form of an entry in a book or otherwise, made as a memorandum of any act, transaction, occurrence or event shall be admissible in evidence in all trials, hearings and proceedings in any cause of suit in any court, or before any officer, arbitrators, or referees, in proof of said act, transaction, occurrence or event if it was made in the regular course of any business and it was the regular course of such business to make such memorandum or record at the time of such act, transaction, occurrence or event or within a reasonable time thereafter. All other knowledge by the entrant or maker, may be shown to affect its weight but not its admissibility. The term "business" shall include business, profession, occupation and calling of every kind. The lack of an entry regarding any act, transaction, occurrence or event in any writing or record so proved may be received as evidence that no such act, transaction, occurrence or event did, in fact, take place. Any photostatic or photographic reproduction of any such writing or record shall be admissible in evidence in any such trial, hearing or proceeding by order of the court, made within its discretion, upon motion with notice of not less than 4 days. All circumstances of the making of such photostatic or photographic reproduction may be shown upon such trial hearing or proceeding to affect the weight but not the admissibility of such evidence."

Record of physicians: availability of information to other physicians

The interest of the patient is paramount in the practice of medicine, and everything that can reasonably and lawfully be done to serve that interest must be done by all physicians who have served or are serving the patient. When a colleague who is presently treating a patient requests records from another physician who has formerly treated the patient, that former physician should promptly make his records available to the attending physician.

No set rule can be laid down to cover the manner in which the records are to be transmitted to the attending physician. Under some conditions, a personal inspection of the records might suffice; under others, an oral report of what is contained in the records would be of help; or in other circumstances, a summary of the records might be made. In extreme cases, a physician might lend his complete record to the attending physician.

The manner of making the report — or the information contained therein — available to the succeeding

AUTHORIZATION TO TRANSFER RECORDS

Date: __________

To: ________________, M.D.

I hereby authorize you to transfer or make available to ______________, M.D., ________________ (address) all the records and reports relating to my case.

Signed ________________

American Medical Association, Office of the General Counsel, *Medicolegal Forms With Legal Analysis.*

physician is immaterial and will depend on the circumstances of each case. Certainly, however, the attending physician should not demand or expect more information from the former physician than is necessary to give the patient adequate care in the present illness.

It is assumed, of course, that proper authorization for the use of these records has been granted by the patient.

It is unethical for a physician who formerly treated a patient, to refuse for any reason to make his records of that patient promptly available on request to another physician presently treating the patient. (from AMA Judicial Council Opinions and Reports — 1977).

Sale or purchase of physician's records

A physician retiring from practice may not ethically *sell* his patients' records to another physician. His records have been developed during the physician-patient relationship. To sell records would tend to make the patient subject to barter to the highest bidder. For the patient's benefit, however, but only with his consent, these records may be transferred to a physician of his choice. A reasonable charge for secretarial or duplicating service connected with such transfer is not improper.

Further, according to Section 9 of the Principles of Medical Ethics, a physician may not reveal the confidences entrusted in him in the course of medical attendance. The physicians' records summarizing these confidences are cloaked with this same protection. To transfer a patients' records without his consent would violate this confidence.

A physician may not ethically *purchase* such records from a retiring physician or from the estate of a deceased physician. (from AMA Judicial Council Opinions and Reports — 1977)

In Michigan, patients may review and obtain copies of hospital medical records. They may also request corrections or make addenda.

Miscellaneous comments

Communication problems affect the physician-patient relationship. Illness is an emotionally charged experience for the patient. If a physician neglects needs of a patient, he may well feel very alienated by this lack of sensitivity. There are several categories of communication that can affect the physician-patient relationship.

1. Use of technical jargon — Many physicians will tend to use medical terms that are not easy for the patient to understand.

This may frustrate patients who never really understand their situation. In a case in which there is a bad result, the patient may feel that he was never informed or gave consent for the treatment or procedure.

Patients many times feel intimidated by the medical jargon that the physician provides. They may not feel comfortable in asking questions that could later become very important.

2. Colleague remarks — Remarks by physicians about treatments and procedures of other physicians can cause considerable communication, and ultimately legal, problems. Inappropriate colleague remarks — loose talk about colleagues — can lead to legal consequences.

Some physicians make inappropriate remarks as a means of bolstering their own ego and status with patients.

Inappropriate remarks can cause patients to believe that they were treated in a negligent or injurious manner and force a liability.

3. The telephone is an essential part of the physician's communication with the patient.

Good telephone communication between the physician or his employees and patient is absolutely essential. Many malpractice situations have developed or have been made worse by a communications breakdown that could have been avoided. Document phone calls in your medical record.

Calls that are emergencies or medical problems must receive priority for physician response.

Calls in which the patient threatens to sue should receive immediate priority since interventions at this point may stop a suit.

4. Communication of need of second opinion — Physician must be aware of the usefulness of second opinions and be willing to utilize them as a deterrent to liability.

AMA finds public supports MDs in malpractice issues

During the past decade, the AMA has monitored closely the opinions of physicians and the public on key health care issues. This year, the AMA conducted 1,000 telephone opinion interviews with randomly selected physicians. Interviews were conducted during the week of August 9-16. The issues discussed in these interviews included medical malpractice.

Results discussed earlier show a renewed increase in physicians' concerns about malpractice and professional liability premiums. One issue that has emerged is related to the ethics of "going bare" without informing patients and colleagues. A factor motivating this situation is the fact that more and more malpractice suits name several physicians and/or a hospital as well. If any one physician has no insurance, the burden on the other co-defendants is increased. The AMA asked physicians' opinions on this issue.

"Another issue is malpractice and professional liability insurance. Do you feel that it is ethical for a physician to practice medicine without professional liability insurance and not inform patients and colleagues?"

Ethical/Strongly	**20%**
Ethical	**19%**
Undecided	**10%**
Not Ethical	**13%**
Not Ethical/Strongly	**38**

A sharp polarization of physician opinion is evidenced by the high percentages in both "strongly" categories. The weight of opinion favors the "not ethical" position. However, almost 40 percent of physicians believe such practice is ethical and 10 percent are as yet undecided.

In a similar vein, opinions were asked on issues surrounding the physician/hospital relationship and malpractice.

"Hospitals should be informed concerning malpractice judgments against physicians who use their facilities regularly."

Agree/Strongly	**63%**
Agree	**23%**
Undecided	**2%**
Disagree	**4%**
Disagree/Strongly	**8%**

While the ethics question showed a balance of views, reaction to hospitals being informed of malpractice judgments against admitting physicians was much more one-sided. As indicated, 86 percent of physicians agreed that such information should be transmitted to hospitals.

Most common allegations by specialty

(Pennsylvania Medical Society Liability Insurance Company's Risk Management Documentation.)

General Surgery

1. Negligent trauma management
2. Negligent treatment of fracture
3. Damaged structures during surgery
4. Failure to diagnose and/or treat appendicitis
5. Nerve damage during surgery
6. Post-operative wound infection

Orthopedic surgery

1. Negligent treatment of fracture
2. Failure to diagnose fracture
3. Post-operative complication due to negligent surgery
4. Post-operative nerve damage
5. Negligent total hip replacement
6. Surgery, wrong side/limb
7. Post-operative wound infection

Obstetrics/Gynecology

1. Negligent performance of elective sterilization procedure
2. Complications during vaginal delivery (involving mother)
3. Injury to infant at birth
4. Retained sponge, surgical instrument, etc.
5. Complications post-total abdominal hysterectomy
6. Negligent pre-natal care

General/Family Practice

1. Negligent drug therapy
2. Failure to diagnose carcinoma
3. Negligent treatment of cardiac condition
4. Failure to diagnose fracture
5. Negligent management of diabetes
6. Negligent obstetrical care

Internal Medicine

1. Negligent drug therapy
2. Damaged structures during treatment
3. Negligent management of cardiac condition
4. Negligent administration of chemotherapy

Neurosurgery

1. Negligent treatment of head trauma
2. Negligent management of disc problems
3. Negligent treatment of back pain/injury
4. Post-operative emboli
5. Bovie burns during surgery
6. Post-operative wound infection

Radiology

1. Failure to diagnose fracture
2. Negligent administration and management of contrast media
3. Failure to diagnose carcinoma
4. Perforation of bowel during barium enema

Emergency Medicine

1. Negligent treatment of laceration
2. Failure to diagnose fracture
3. Negligent treatment of trauma
4. Failure to remove foreign body

Anesthesiology

1. Tooth damage
2. Damaged structures due to negligent anesthesia management
3. Cardiac arrest during surgery
4. Post-operative brain damage
5. Esophageal intubation

As more malpractice suits name both physicians and a hospital, professional liability insurance is mentioned more frequently as a requirement for admitting privileges.

"Hospital medical staffs should require evidence of professional liability insurance for staff privileges."

Agree/Strongly	**46%**
Agree	**16%**
Undecided	**4%**
Disagree	**14%**
Disagree/Strongly	**19%**

Two major points should be noted from these results:

- The weight of opinion (62 percent) is strongly on the agree side.
- Again, however, the the issue is very polarized with almost 20 percent of physicians *strongly* opposed to this requirement and 46 percent *strongly* in support.

An issue that has been examined within the health services research literature is *the extent to which malpractice claims are actually the result of medical negligence.* Various "culprits" responsible for the surge in malpractice suits have been named. These include lawyers, tort law and a litigious public. It is informative, therefore, to examine physicians' own views about the relationship between medical negligence and malpractice claims.

"In your own opinion, what percentage of malpractice claims are the result of medical negligence?"

On average, physicians polled believe that 22 percent of all malpractice claims are the result of actual negligence.

Percent of Claims resulting from Medical Negligence	Number of Physicians	Percent of Total Sample
0-10	282	28
11-49	321	32
50 +	216	22

The most striking aspect of these findings is the high degree of dispersion in responses. While 282 physicians, or 28 percent of the sample say 10 percent or fewer claims are justified, 216 physicians (22 percent) indicate that 50 percent or more of all claims are the result of medical negligence.

Because of the rising cost of professional liability insurance, there is a strong impetus for physicians to identify and pursue *methods of reducing their malpractice risk.* Physicians were asked their opinions as to the effectiveness of various strategies on programs for this purpose. The data collected address two issues:

- How do physicians rank the effectiveness of risk reduction alternatives?
- Is physician opinion in this regard similar to the experience of insurance executives who deal with malpractice claims on a daily basis?

"Now I'm going to read you a list of methods that have been suggested to help avoid malpractice suits against physicians. For each method, would you tell me if you think it would be *very effective, somewhat effective,* or only *slightly effective* in helping to avoid malpractice suits against physicians?"

Method	**% Very Effective**
More peer review such as tissue committees	**34**
Required courses of continuing medical education	**34**
Better doctor-patient rapport	**92**
Seminars on risk management and risk avoidance	**35**
Public relations programs to improve physicians' images	**38**

The pattern is strikingly clear. Physicians do not believe any of the proposed methods to reduce malpractice risk are very effective *except improving physician/patient rapport.* This is precisely the factor mentioned by experts in the area of professional liability insurance as the major determinant in patients' decisions to file a malpractice claim. Therefore, physicians are very accurate in their perception of ways to reduce the risk of malpractice claims. As the supply of physicians continues to grow relative to demand, malpractice claims may decline as physicians have more time to spend with patients in developing good personal relationships.

At the same time the AMA was surveying physicians, it conducted 1,504 telephone interviews with randomly selected public respondents. Public interviews also were conducted during the week of August 9-16.

Since the so-called "malpractice crisis" of 1978, the issue of professional liability has been less visible. However, there are recent signs that malpractice claims and judgments are again rising rapidly with inevitable upward pressure on premiums. For this reason, malpractice and related topics were included in both the physician and public surveys this year.

The AMA asked the public:

"As you no doubt know, there have been a lot of cases recently where people have sued doctors for malpractice. Do you think people who sue physicians for malpractice are usually justified in bringing suit, or are they just looking for an easy way to make some money?"

Usually justified in bringing suit	**47%**
Just looking for easy way to make money	**43%**
Not sure	**10%**

"Do you think the amount of money awarded to patients by juries in malpractice suits is usually too much, not enough, or about right?"

Too much	**47%**
Not enough	**7%**
About right	**38%**
Not sure	**8%**

"Do you think that there should be a limit on the amount of money that can be awarded to someone suing a doctor for malpractice?"

Yes	**61%**
No	**35%**
Not sure	**4%**

A majority of Americans do *not* believe that people who sue for malpractice are usually justified in bringing suit. Further, a surprising plurality (47 percent) state that current awards are too high, while only 7 percent believe that not enough money is usually awarded.

Finally, a strong majority favor limits on malpractice awards.

In combination, these findings indicate surprisingly strong pro-physician views on malpractice-related issues. The extent to which these views can be translated into legislative reality should be further explored.

MALPRACTICE CASE HISTORIES

Here's the kind of trouble poor records may create

Types of malpractice suits in which Michigan physicians are involved have not changed much over the years.

"There are only so many ways to get in trouble," observes MSMS Legal Counsel A. Stewart Kerr.

But the number of suits and the size of settlements have jumped geometrically, Mr. Kerr observes.

"There are any number of studies which show the increase in numbers," he says. "And the size of the settlements and the size of the verdicts have gone up like the devil. If the physician doesn't settle at high cost, the case goes to trial and draws the higher verdict."

"I still hear physicians grumbling at cocktail parties that the cost of settlements is high because the insurance companies settle out of court for such great sums," Mr. Kerr continues. "But insurance companies do not settle at those amounts for their health; they settle because they have to."

A case in point, he says, is the following, taken from the files of the firm of Kerr, Russell and Weber. Names have been altered for this presentation, but the incidents described all are true to life.

This case has been selected to illustrate the horrible circumstances under which physicians may find themselves, if they are not careful about their record keeping and other aspects of medical practice. It also illustrates what legal proceedings may do to the physician involved.

This case is first in a series which *Michigan Medicine* will be presenting over the coming months, each of which will be taken from the Kerr, Russell and Weber files. Should MSMS members have questions or desire details on how to avoid such situations, they are invited to submit their questions by letter to A. Stewart Kerr, MSMS, 120 W. Saginaw St., East Lansing, 48823.

Case history

Jones v Dr. Waybelo

The patient, Mrs. Jones, is an 85-year-old immigrant who speaks no English and is terrified by the hospital milieu. Doctor Waybelo, the defendant, is a 32 year old gastroenterologist. Doctor Waybelo performed a gastroscopy on Mrs. Jones and perforated her esophagus.

Perforation of the esophagus is *not* considered malpractice per se. It is a known risk of the procedure and occurs in a certain percentage of cases. If the physician perforates the esophagus, however, he should know it by recognizing that the structures he is seeing through his instrument are not within the esophagus. If a physician suspects this, the patient should be referred for a barium swallow to promptly rule out the laceration. If the condition is promptly discovered and repaired, recovery is anticipated. If the condition is not promptly discovered, it can be a lethal complication, especially in an 85 year old woman.

Doctor Waybelo did not realize what he had done, but a resident suspected. Doctor Waybelo resisted referring the patient for a barium swallow; the resident's insistance finally resulted in a barium swallow which revealed the perforation. The condition was repaired and the patient survived.

Doctor Waybelo re-examined the chart and made some "corrections," starting with the standard consent form for gastroscopy. The form contains blanks for insertion of the specific risks of the procedure discussed with the patient. He had not written in "perforation of esophagus" before the procedure, so he corrected that omission. After that, he went to the progress notes and squeezed in between the applicable lines "r/o perforation, consider barium swallow." This latter chart alteration would not have stood up under scrutiny in court.

This case was settled for a substantial amount of money *before* plaintiff's lawyer really understood the charting "problems." As plaintiff lawyers become more sophisticated in chart reading, the number of malpractice cases based on the records appears to be increasing.

Legal counsel advises MDs to learn to live with mandatory coverage

By Judith Marr
Editor, Michigan Medicine

(See related article, page 57.)

The facts are that the practice of mandatory professional liability coverage in exchange for hospital privileges is here, though it is not forced upon Michigan physicians yet by legislation. Therefore, staff members should consider what to do to make mandatory coverage work well or at least to be able to live with it.

- Diagnosis and intervention in lives of impaired physicians should interest their colleagues most today. Otherwise those who are not their friends will find the impaired physician an easy target for retaliation over any frustrations with the health care delivery system.
- People will not settle or solve problems until they feel they will be better off with a solution than without. Thus, the best approach to hospital staff contract negotiations is to work for a win/win situation, when both sides are happy with the outcome and the relationship can continue.

These were the three major messages brought to hospital chiefs of staff, medical staff leaders and administrators at the second MSMS Medical Staff Relations Conference. MSRC II was staged recently at the Wayne County Medical Society Auditorium.

Featured speakers, respectively, were MSMS Legal Counsel A. Stewart Kerr, Detroit; Richard A. Morin, MD, Intervention and Treatment Subcommittee, MSMS Program to Assist Impaired Physicians, Detroit, and Jerry P. Clousson, JD, LLM, president, Physician Support Services Inc., former director of the AMA Department of Negotiations.

Insurance

Mr. Kerr, who was the first speaker, said discussion about mandatory professional liability insurance may be moot soon, as 12 states have required it by statute, and it is clearly permissible by law in Michigan.

One important question which would have to be answered should coverage become mandatory for hospital privileges, he said, is the matter of credentialing. "One possible solution is to leave it to the medical staff to determine the qualifications of their staff members, including their insurance coverage."

Most physicians do not want mandatory coverage, he acknowledged. "But the bottom line is that the hospitals have the leverage. If they want mandatory coverage, sooner or later they will get it. So it behooves hospital staffs to prepare now for the eventuality and to study the mechanics of such a situation.

"Most of all," he said, "the hospital staff must hang together."

Impairment

Doctor Morin described the physician at high risk of becoming an alcoholic as one who has two of the following three characteristics: (1) faith in chemicals, (2) withdrawal symptoms after ceasing drinking, and (3) an increased tolerance to drugs. "Physicians already have the first characteristic," he said, "It takes just one more."

"Why doesn't the inpaired physician realize what is happening and stop drinking?" he asked. "There is an immense amount of denial. Also, we often give inappropriate feedback to our colleagues, who need help in overcoming this denial."

He asserted that "if you understand alcoholism you understand medicine and psychiatry today. Alcoholism is a very protean illness. It is not simply drunkenness; it involves every organ of the body."

He called for the following stepped intervention program to assist drug and alcohol abusing physicians; (1) gathering forces; (2) gathering facts and people; (3) setting proper priorities; (4) forcing the impaired physician to accept the consequences of abusive behavior; (5) providing faith and hope; (6) detailing the consequences; (7) providing a "what if you don't stop" clause; (8) following through; (9) treating all the family, and (10) providing aftercare.

"If anything has been missing in the medical care of alcohol and drug abusers in the past," he said, "it has been the use of punitive measure, coupled with the offering of faith and hope."

Negotiations

When it comes to negotiating hospital staff contracts, said Mr. Clousson, a good approach for achieving the win/win situation is, "I want to advance my interests and help you achieve your goals as far as they can go together."

He cautioned physicians to keep their alternatives open for solutions, and not to come forward with proposals too soon.

"Try to solve problems in an advantageous way to physicians and administrators both," he said.

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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960 Agard St.
Benton Harbor 49022

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Dearborn 48124

Rajalakshmi Cheruvu, MD FP
46184 Green Valley Ct.
Detroit 48170

Gary D. Christopher, MD FP/EM
5661 Hubbell
Dearborn Heights 48127

Steven G. Dulla, MD GP
610 Tobin #206
Inkster 48141

Mitchell Elkiss, DO N
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Southfield 48076

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45192 Riveredge
Plymouth 48170

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Troy 48098

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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Arbitration can succeed if ruled constitutional

By Charles R. Downs
East Lansing

Ms. Baerwaldt

The 1977 law that made arbitration an optional substitute for malpractice suits has not been a smashing success. But if doubts about its constitutionality can be resolved, it might be improved and could eventually become a more effective bulwark against rising costs of malpractice insurance.

This was the message that Nancy A. Baerwaldt, Commissioner of Insurance, Michigan Insurance Bureau, brought to physicians attending the MSMS Public Affairs Leadership Conference on Oct. 28 at Long's Convention Center in Lansing.

Baerwaldt said a case, challenging the constitutionality of the Medicaid Malpractice Arbitration Act, is now before the Michigan Supreme Court and that a decision may be made by the end of 1982. If the law is upheld, then the Michigan Legislature would have greater incentive to attempt to improve the basic law.

"I think the legislators have a pretty flexible role if they get a signal from the Supreme Court so they won't do something that results in nothing," the commissioner pointed out.

The main failing of the law according to its proponents has been that too few people have chosen the arbitration option, a decision that can be made only in advance of hospitalization and/or certain medical and surgical procedures.

Baerwaldt said the law was to have been evaluated in 1979 but that so few people exercised the arbitration option that the state did not have enough cases at the time to make a valid study.

Now, however, the state has 370 cases which have gone through the arbitration process. A thorough evaluation will be made through a state contract with Applied Social Research, an Ann Arbor-based firm.

The purpose will be to see how efficient and how effective the arbitration process has been, Baerwaldt said. She indicated that the study will look at changes in class rates, the size of awards made through arbitration with those made through suits, and the viewpoints of doctors, lawyers and others involved.

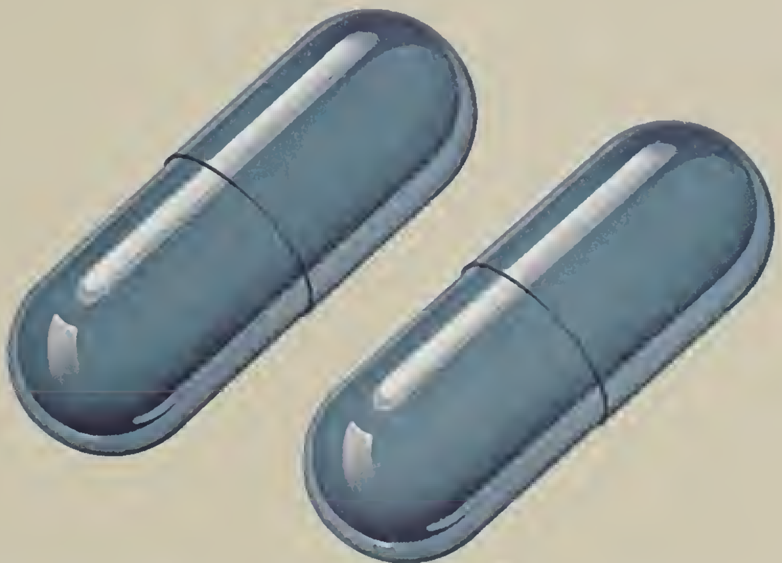
Despite the fact that arbitration with those made through suits, and the viewpoints of doctors, lawyers and others involved.

Despite the fact that arbitration has not been as widely used as proponents hoped, the total annual charges for malpractice insurance increased only moderately— from about $66 million in 1979 to $68 million in 1971. Baerwaldt noted. The increase is consistent with figures for life insurance charges in that period, she said.

One of the arguments against constitutionality of the arbitration process, Baerwaldt said, is the issue of whether or not the plaintiff is being denied due process when the law requires the presence of a physician on an arbitration committee.

Another constitutional issue is whether or not a citizen can legally waive his or her rights to file a suit.

Mr. Downs is a free-lance writer.



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Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS: *Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use).* In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephradine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro.* Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis

produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

Diuretics (potent "loop diuretics," e.g., furosemide and ethacrynic acid) — Enhanced possibility for renal toxicity.

Probenecid — Increased and prolonged blood levels of cephalosporins, resulting in increased risk of nephrotoxicity.

Drug/Laboratory Test Interactions: After treatment with cephradine, a false-positive reaction for glucose in the urine may occur with Benedict's solution, Fehling's solution, or with Clinitest® tablets, but not with enzyme-based tests such as Clinistix® and Tes-Tape®. False-positive Coombs test results may occur in newborns whose mothers received a cephalosporin prior to delivery. Cephalosporins have been reported to cause false-positive reactions in tests for urinary proteins which use sulfosalicylic acid, false elevations of urinary 17-ketosteroid values, and prolonged prothrombin times.

Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy: Teratogenic Effects/Impairment of Fertility — Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

ADVERSE REACTIONS: Untoward reactions are limited essentially to G.I. disturbances and, on occasion, to hypersensitivity phenomena. The latter are more likely to occur in persons who have previously demonstrated hypersensitivity and those with a history of allergy, asthma, hay fever, or urticaria.

(continued on next page)

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(continued)

The following adverse reactions have been reported following use of cephradine: G.I. — Symptoms of pseudomembranous colitis can appear during antibiotic therapy; nausea and vomiting have been reported rarely. Skin and Hypersensitivity Reactions — mild urticaria or skin rash, pruritus, joint pains. Blood — mild transient eosinophilia, leukopenia and neutropenia. Liver — transient mild rise of SGOT, SGPT, and total bilirubin with no evidence of hepatocellular damage. Renal — transitory rises in BUN have been observed in some patients treated with cephalosporins; their frequency increases in patients over 50 years old. In adults for whom serum creatinine determinations were performed, the rise in BUN was not accompanied by a rise in serum creatinine. Others — dizziness, tightness in the chest, and candidal vaginitis.

DOSAGE: Adults — For respiratory tract infections (other than lobar pneumonia) and skin and skin structures infections: 250 mg q. 6 h or 500 mg q. 12 h. For lobar pneumonia: 500 mg q. 6 h or 1 g q. 12 h. For uncomplicated urinary tract infections: 500 mg q. 12 h; for more serious UTI, including prostatitis, 500 mg q. 6 h or 1 g q. 12 h. Severe or chronic infections may require larger doses (up to 1 g q. 6 h.).

Children over 9 months of age — 25 to 50 mg/kg/day in equally divided doses q. 6 or 12 h. For otitis media due to *H. influenzae:* 75 to 100 mg/kg/day in equally divided doses q. 6 or 12 h but not to exceed 4 g/day. Dosage for children should not exceed dosage recommended for adults. There are no adequate data available on efficacy of b.i.d. regimens in children under 9 months of age.

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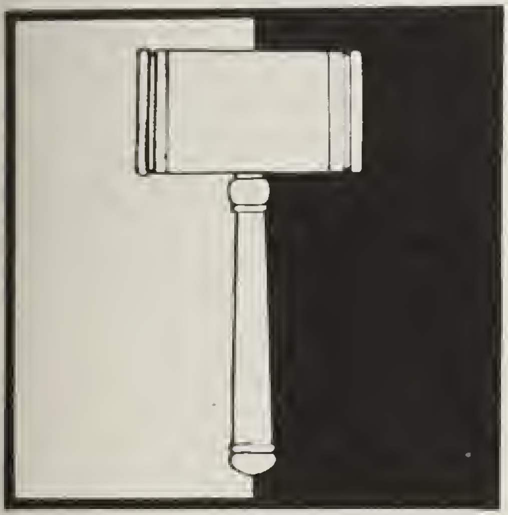
MSMS finds 35 percent increase in reported closed claims in Michigan

By Deborah Zannoth
East Lansing



The MSMS Bureau of Economics has completed its current update on closed malpractice claims reported by insurance companies doing business in Michigan. The data represent the reports from these companies on any malpractice claims which were settled through the legal process between June 1981 and June 1982. However, even though 597 cases completed litigation in this time, many of the claims were initiated in prior years, some as far back as 1974.

The 597 claims represent an increase of 35 percent over reported closed claims of the previous year, and a 127 percent increase for the entire reporting period, which extends back to 1975. It now appears that a number of reported cases initiated during the malpractice crisis in the mid-seventies have finally cleared the system and culminated in a judgment.

There are limits in compiling malpractice claims data due to the lengthy legal proceedings, and an accurate accounting of current malpractice claims is delayed. MSMS receives malpractice statistics only upon completion of litigation; thus the final analysis of the data is delayed several years.

Since MSMS started its survey of reported closed malpractice claims in 1975, a total of 2,142 suits have completed the legal process. This figure includes those claims which were dismissed by the court as well as those which were abandoned by the plaintiff. For the third consecutive year, no indemnity was granted in 42 percent of the total number of claims processed.

The restrictions in the data make it formidable to predict with confidence any meaningful future trends. However, of the total 2,142 claims processed, the average time elapsed between injury and reported date is 25 months. The average time between injury and closure is 55 months and the average time between reported injury and closure is 30 months. The average time between reported date and closure has decreased by two months, whereas the other figures have increased at a gradual rate of two months per year for the last two years.

The average physician involved in litigation is 41-50, self-employed and board certified. The percent of FMGs involved is 24 percent, which is not equal to the amount of FMGs currently practicing in Michigan.

Physicians specializing in general surgery continue to be those most often involved in malpractice litigation. One possible explanation for this is that surgeons are procedure oriented and thus are exposed more than the average practicing physician population.

Table I (claims characteristics) indicates a rise over time in the gross average paid as well as the average dollar amount for claims with awards. There is also a rising trend toward larger settlements **(Table II)**. From 1976 there has been an increasing number of settlements over $100,000, with no real decrease in the settlements of less than $10,000.

Included in this year's data are two charts **(Tables X and XI)** relating to rates per 100 physicians and per 1,000 population. The population base of each zip code was determined, along with the number of claims, to determine the rates.

The data included in this report do not provide an entire overview of the malpractice situation. The information does not incorporate self-insured hospital statistics, the physicians who are self-insured, or physicians self-insured through their hospitals.

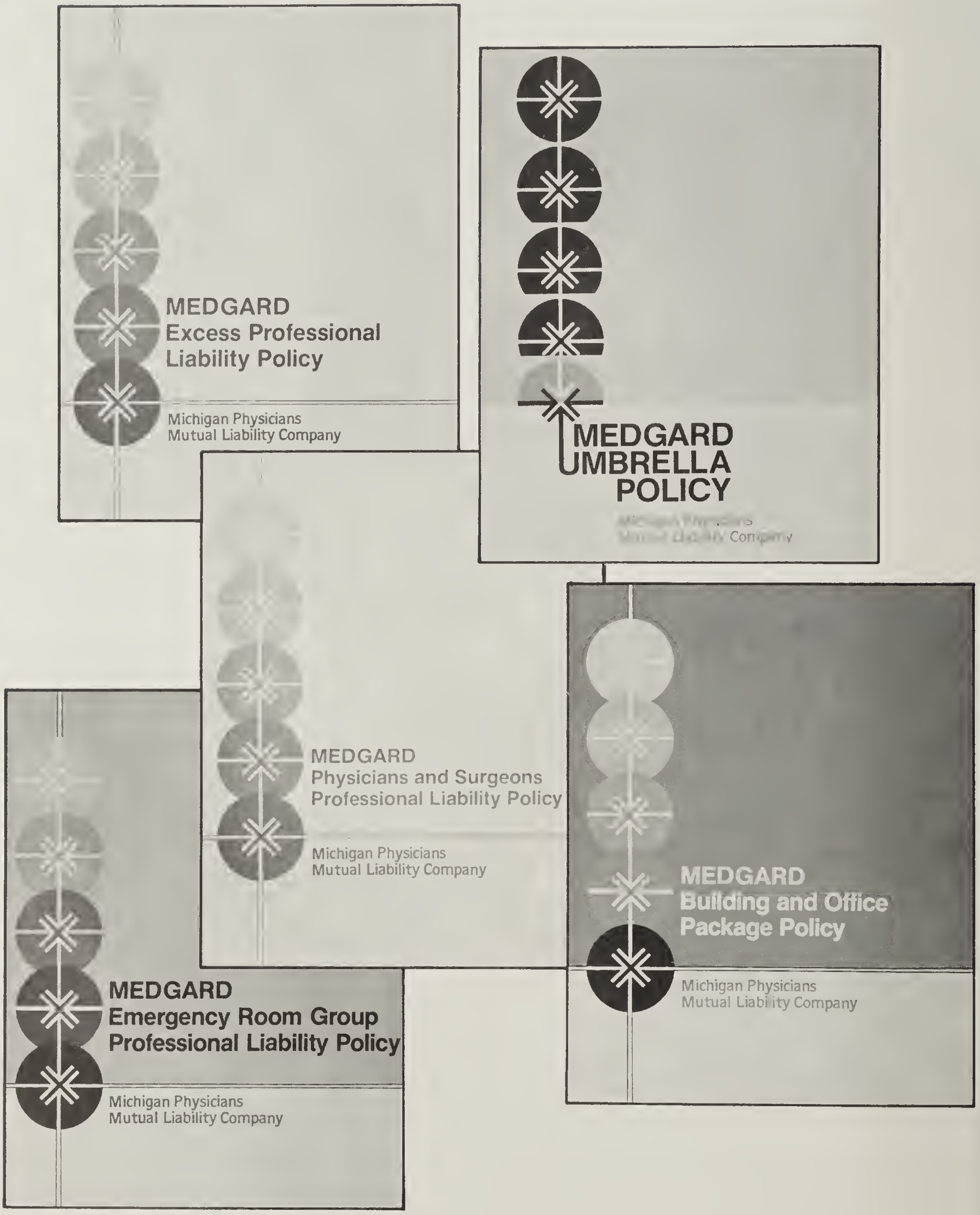
Also not represented in this information are claims being adjudicated under the Michigan Arbitration Code. The MAC was initiated on January 1, 1976. As of October 31, 1982, a total of 333 were filed, of which 224 have closed and 157 are still pending.

MSMS would like to thank the Michigan Insurance Bureau and the Department of Licensing and Regulation for their assistance in completing this report.

See accompanying tables, pages 24, 26, 28 and 32.

Ms. Zannoth is assistant to the MSMS Bureau of Economics

WHAT YOU SEE.



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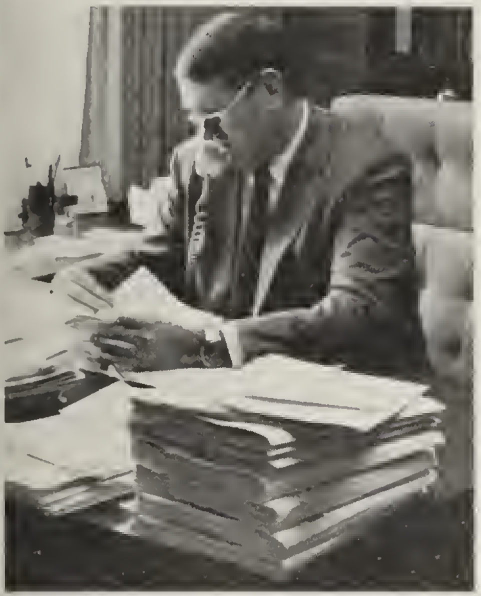
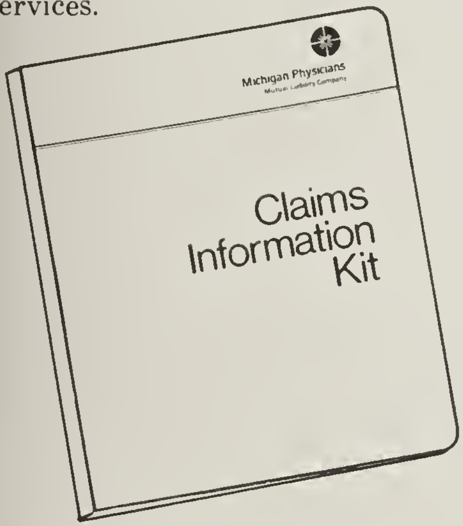


Service. Claims service is what you buy a professional liability policy for in the first place. Our policies are backed by the most experienced professional liability claims staff in Michigan. Our claims representatives return your phone calls and keep you informed of the progress of any claim in which you may be involved. These professionals and the excellent defense attorneys assighed to represent our policyholders have helped Michigan Physicians build our excellent reputation for claims services.



Communication. Our Closed Claim Questionnaire and the newly revised Claims Information Kit are examples of how we communicate with the physicians we insure. The MUTUAL MONITOR (our quarterly newsletter), risk management seminars, and special meetings at hospitals are other examples of how we are bringing information to the medical profession on a continuing basis.

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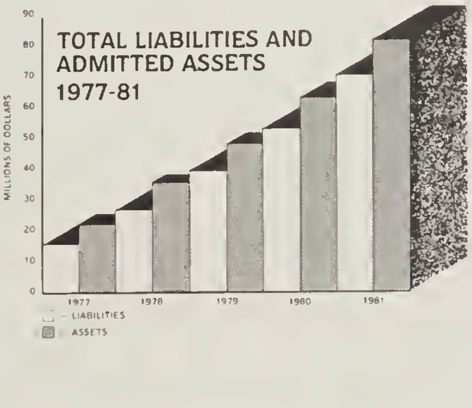

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Endorsement. We are the only professional liability company endorsed by the Michigan State Medical Society. The support of MSMS has helped our company grow from an idea in 1975—to Michigan's leading physician insurer. We value our relationship with the members of MSMS and we are proud to display their official seal.

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Table I
Claims Characteristics

Year	1970	1971	1972	1973	1974	1975	1976
Number of Claims	5	7	31	78	213	335	366
Total Paid	$16,667	$52,200	$576,762	$795,676	$2,287,484	$4,481,320	$5,420,655
Gross Average Paid	NA	$7,457	$18,605	$10,201	$10,739	$13,377	$14,811
% With no Indemnity Paid	(4) 80%	(3) 43%	(15) 48%	(32) 41%	(95) 45%	(145) 43%	(140) 38%
Average $ Amount for Claims With Awards	$16,667	$13,050	$36,048	$17,297	$19,385	$23,585	$23,985

Year	1977	1978	1979	1980	1981
Number of Claims	326	247	227	184	100
Total Paid	$3,428,790	$2,468,724	$3,455,031	$3,069,390	$438,629
Gross Average Paid	$10,518	$9.995	$15,220	$16,681	$4,386
% With no Indemnity Paid	(127) 39%	(119) 48%	(101) 44%	(74) 40%	(51) 51%
Average $ Amount for Claims With Awards	$17,317	$19,287	$27,421	$8,952	

Table II
Distribution by Thousands of Indemnity Paid

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
$ 0- 10	0	3	5	27	73	122	156	147	86	80	74	44
$ 11- 20	1	0	3	8	10	20	20	13	11	9	9	2
$ 21- 30	0	0	1	5	12	12	10	3	7	3	6	1
$ 31- 40	0	1	0	2	4	6	2	8	4	4	4	0
$ 41- 50	0	0	2	2	6	2	5	6	5	5	7	0
$ 51- 60	0	0	1	0	0	3	2	3	1	2	0	0
$ 61- 70	0	0	2	0	1	4	3	3	3	5	1	0
$ 71- 80	0	0	0	1	3	4	4	3	1	3	0	0
$ 81- 90	0	0	1	0	1	0	3	1	2	0	1	2
$ 91-100	0	0	0	0	8	7	6	10	6	10	5	0
$101-200	0	0	1	1	0	10	14	2	2	4	2	0
$201-300	0	0	0	0	0	0	0	0	0	1	0	0
$301-400	0	0	0	0	0	0	1	0	0	0	0	0
over 400	0	0	0	0	0	0	0	0	0	0	1	0

Table III
Claims Reporting Data

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
Number of Cases	5	7	31	78	213	335	366	326	247	227	184	100
Average Number of Months — Injury to Report	10	11	17	23	20	21	24	27	30	28	28	32
Average Number of Months — Injury to Close	85	76	79	72	63	56	55	55	56	51	43	38
Average Number of Months — Report to Close	75	66	61	49	43	35	31	29	26	23	16	6

More on page 26

easy to take

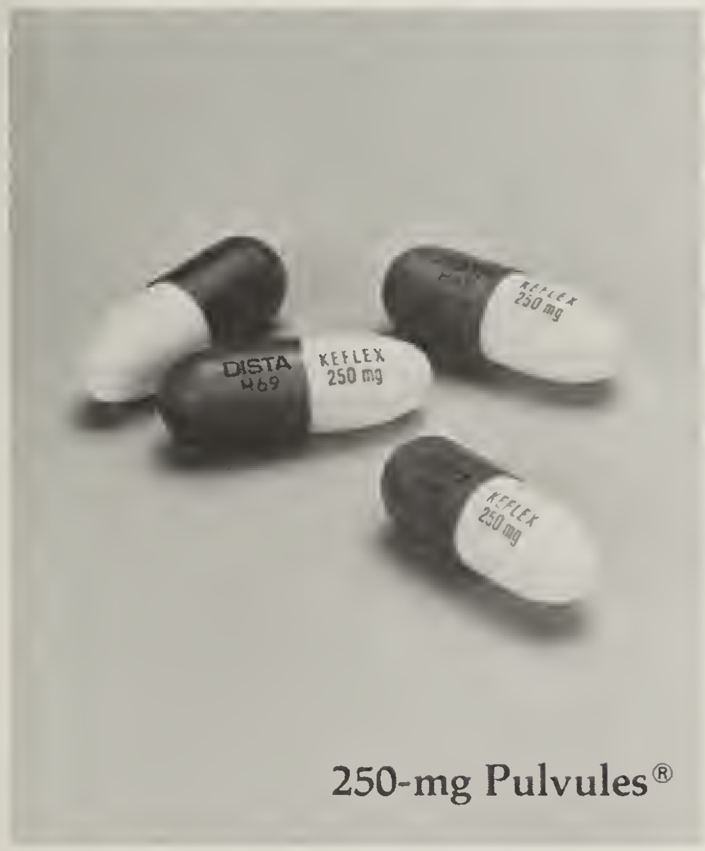

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Table IV
Physician Characteristics

	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
Average Age of Physician	32	39	40	39	43	43	43	44	47	47	47	N/A
Physician Age Distribution												
30 and under	25%	17%	0	0	1%	2%	1%	0	1%	1%	0	2%
31-40	25%	0	33%	27%	28%	31%	30%	29%	25%	25%	22%	35%
41-50	50%	50%	41%	52%	40%	37%	33%	39%	39%	31%	34%	35%
51-60	0	33%	19%	15%	27%	21%	23%	27%	24%	25%	30%	14%
60 and over	0	0	7%	6%	4%	9%	12%	10%	10%	18%	14%	14%
% of FMGs	N/A	29%	6%	12%	19%	25%	21%	26%	18%	29%	27%	22%
Board	(4)	(6)	(20)	(50)	(148)	(198)	(244)	(194)	(173)	(133)	(129)	(67)
Certified	80%	85%	65%	68%	69%	59%	67%	60%	70%	59%	70%	67%

Table V
Claims Against Physicians By Type of Practice

Type of Practice	1970	1971	1972	1973	1974	1975	1976	1977	1978	1979	1980	1981
Institutional	0	1	1	0	2	2	3	6	0	0	1	1
PC/Partnership	0	2	9	24	73	130	138	108	112	87	93	36
Self-Employed	5	4	20	49	129	184	208	192	122	125	83	55
Employed	0	0	1	5	7	16	16	15	10	13	7	7

Table VI
Suits By AMA Specialty Classification

General Surgery	741
General Practice	332
Surgery, Orthopedic	225
Internal Medicine	210
Radiology, Diagnostic	87
Family Practice	60
Surgery, Plastic	51
Surgery, Neurological	45
Gynecology	42
Pediatrics	39
Anesthesiology	37
Surgery, Thoracic	36
Surgery, Cardiovascular	31
ER Medicine	29
Pathology	23
Dermatology	16
Psychiatry	15
Surgery, Pediatric	14
Cardiovascular Diseases	11
Opthalmology	11
Physical Medicine & Rehabilitation	11
Neurology	10
Neurology, Child	9
Surgery, Abdominal	8
Otorhinolaryngology	7
Rhinology	7
Nuclear Medicine	5
Surgery, Colon & Rectal	4
Surgery, Hand	4
Allergy	3
Gastroenterology	3
Obstetrics	2
Rheumatology	2
Geriatrics	1
Otology	1
Pulmonary Diseases	1
Surgery, Traumatic	1
Miscellaneous	7

Table VII
Geographical Distribution of Claims

Zip Code	Counties Included	Number of Claims
480	Macomb, Oakland, St. Clair	540
482	Wayne	458
481	Livingston, Monroe, Oakland, Washtenaw, Wayne	356
490	Allegan, Barry, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	123
495	Kent	77
489	Ingham	62
485	Genesee	56
488	Clinton, Eaton, Gratiot, Ingham, Ionia, Isabella Livingston, Shiawassee	61
492	Calhoun, Hillsdale, Ingham, Jackson, Lenawee	52
486	Arenac, Clare, Gladwin, Midland, Ogemaw, Oscoda, Roscommon, Saginaw	47
494	Mason, Muskegon, Newaygo, Oceana, Ottawa	47
497	Alpena, Charlevoix, Cheboygan, Chippewa, Crawford, Emmett, Luce, Mackinac, Montmorency, Otsego, Presque Isle	34
496	Antrim, Benzie, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Osceola, Wexford	31
498	Alger, Delta, Dickinson, Marquette, Menominee, Schoolcraft	23
484	Genesee, Huron, Lapeer, Oakland, Sanilac	18
487	Alcona, Bay, Iosco, Tuscola	13
493	Kent, Lake, Mecosta, Montcalm	9
499	Baraga, Gogebic, Houghton, Iron, Keweenaw, Ontonagon	8
491	Berrien	3
	Invalid Zip Codes	124
	TOTAL	2,142

More on page 28

GRAND TRAVERSE RESORT COMPLEX INITIATES SUBSTANTIAL GROWTH PROGRAM.

Eleven-million-dollar improvement and construction program seeks to entrench Grand Traverse Resort as the Midwest's finest resort facility.

"The patronage and confidence our guests and condominium owners have placed in us compel us to *set* the standards for resort living in northern Michigan — not just meet them," stated President Paul L. Nine as he recently detailed several major steps forward in the growth and development program for the three-year-old hotel and condominium villa complex.

Besides completion of the new Jack Nicklaus-designed golf course, growth and expansion programs also provide for the construction of a complete Information Center building at the entrance of the Grand Traverse Resort complex. The program also entails development of lots adjacent to and within the new Nicklaus golf course. The new lots will contain both private home sites and villas, reflecting the success of the resort's continuing construction and sales program. When complete, these projects are expected to represent nearly eleven million dollars in major improvements.

Grand Traverse Resort was formerly known as Grand Traverse Village. The name change was effected to more clearly reflect the objective of positioning the complex among the finest resort facilities in the country and without peer in the midwestern United States. Grand Traverse Resort is situated six miles north of Traverse City, with Grand Traverse Bay in clear view from its grounds. Since opening in 1980, the resort hotel has accommodated over 80,000 guests and has attracted nearly 100 condominium owners.

Golfing legend and course architect, Jack Nicklaus, inspects progress of the tournament course now under construction. Upon completion in 1984, the resort will have two superb 18-hole courses.

Careful preservation and use of the site's natural beauty is one of the most prideful accomplishments of Grand Traverse Resort, which has been the recipient of several awards for its painstaking conservation practices and techniques.

Additional equipment purchases and facilities improvements are expected to make our complete exercise and sports complex second to none in the Midwest.

These recently completed terrace and mid-rise Condovillas bring the Grand Traverse Resort's total to 123. Long-range plans also include a shopping mall and commercial development.

The 250-room Grand Traverse Hilton Hotel is the focal point of the resort's recreation, entertainment and dining facilities. A hotel-administered rental program provides Condovilla owners with income-producing property.

GRAND TRAVERSE RESORT

Phone: 1-800-632-4310

Grand Traverse Village, MI 49610

Table IX
Others Contributing to Injury

Attending Physician	531
House Staff	241
Nurse, RN	91
Consultant	56
Radiologist	31
Patient	18
Nurse, LPN	12
Radiology Technician	11
Physician's Assistant	10
Pathologist	8
Anesthetist	6
Laboratory Technician	6
Pharmacist	6
Anesthesiologist	5
Physical Therapist	3
OR Technician	2
Other Technician	2
Aide	1
Orderly	1
Maintenance Personnel	1
Administrator	1

Table VIII
Average Indemnity Paid By Zip Code Area

Zip Code	Counties Included	Average Indemnity Paid
484	Genesee, Huron, Lapeer, Oakland, Sanilac	$31,269.00
488	Clinton, Eaton, Gratiot, Ingham, Ionia, Isabella, Livingston, Shiawasee	27,493.00
496	Antrim, Benzie, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Osceola, Wexford	23,713.00
491	Berrien	19,382.00
495	Kent	18,706.00
481	Livingston, Monroe, Oakland, Washtenaw, Wayne	14,272.00
485	Genesee	13,641.00
489	Ingham	12,116.00
482	Wayne	11,959.00
497	Alpena, Charlevoix, Cheboygan, Chippewa, Crawford Emmett, Luce, Mackinac, Montmorency, Otsego, Presque Isle	11,824.00
493	Kent, Lake, Mecosta, Montcalm	11,306.00
490	Allegan, Barry, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	10,922.00
494	Mason, Muskegon, Newaygo, Oceana, Ottawa	9,635.00
492	Calhoun, Hillsdale, Ingham, Jackson, Lenawee	9,112.00
480	Macomb, Oakland, St. Clair	9,110.00
487	Alcona, Bay, Iosco, Tuscola	9,058.00
499	Baraga, Gogebic, Houghton, Iron, Keweenaw, Ontonagon	8,969.00
498	Alger, Delta, Dickinson, Marquette, Menominee, Schoolcraft	4,567.17
486	Arenac, Clare, Gladwin, Midland, Ogemaw, Oscoda, Roscommon, Saginaw	3,355.00

Table X
Claims Per Capita (Population)

Zip Code	Counties Included	Rate per 100,000 population
489	Ingham	42
480	Macomb, Oakland, St. Clair	33
481	Livingston, Monroe, Oakland, Washtenaw, Wayne	28
482	Wayne	27
496	Antrim, Benzie, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Osceola, Wexford	23
495	Kent	23
490	Allegan, Barry, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	21
497	Alpena, Charlevoix, Cheboygan, Chippewa, Crawford, Emmett, Luce, Mackinac, Montmorency, Otsego, Presque Isle	20
486	Arenac, Clare, Gladwin, Midland, Ogemaw, Oscoda, Roscommon, Saginaw	20
485	Genesee	20
492	Calhoun, Hillsdale, Ingham, Jackson, Lenawee	17
488	Clinton, Eaton, Gratiot, Ingham, Ionia, Isabella, Livingston, Shiawassee	15
498	Alger, Delta, Dickinson, Marquette, Menominee, Schoolcraft	14
494	Mason, Muskegon, Newaygo, Oceana, Ottawa	14
499	Baraga, Gogebic, Houghton, Iron, Keweenaw, Ontonagon	9
493	Kent, Lake, Mecosta, Montcalm	8
487	Alcona, Bay, Iosco, Tuscola	8
484	Genesee, Huron, Lapeer, Oakland, Sanilac	5

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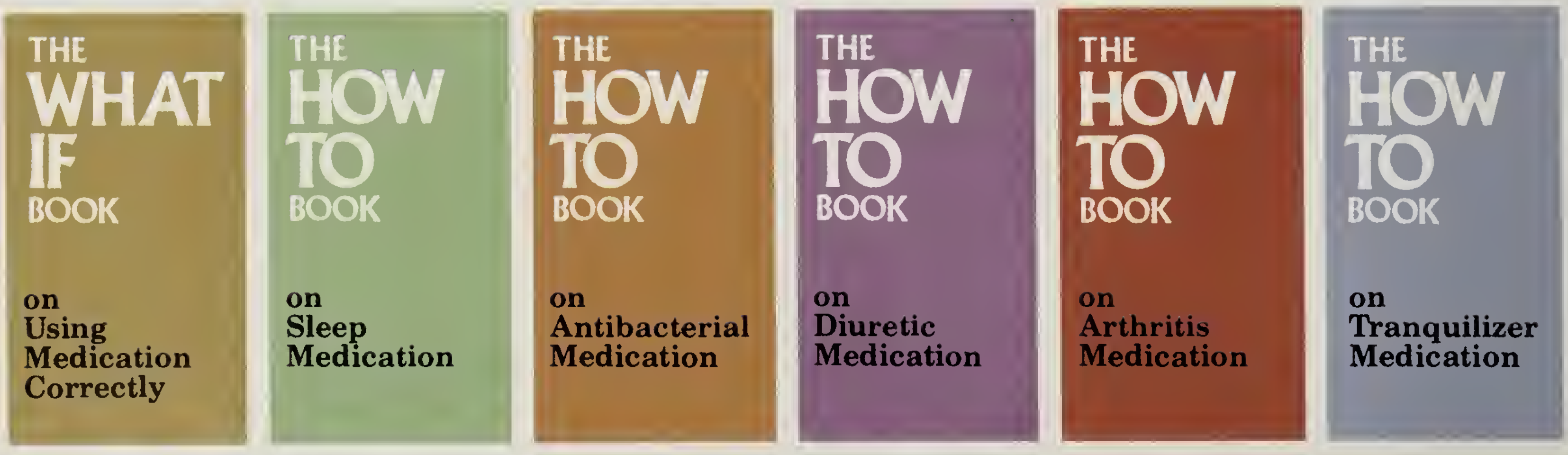

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MPMLC looks ahead to 1983

By Robert M. Leitch, MD
Battle Creek

In reviewing 1982's experience for Michigan Physicians Mutual Liability Company (MPMLC), I am concerned both as a physician and as president of Michigan's leading insurer of physicians. As a physician, I have a great deal of sympathy for our colleagues who are being sued at an ever-increasing rate. Practicing medicine in 1982 carried the highest risk for physicians in terms of potential liability in our history of caring for Michigan patients.

Some of the recent headlines speak to the magnitude of the problem: In Flint, "Mom, Child Get $8.4 Million In Birth-Trauma Case"; In Detroit, "Brain-Damaged Boy Wins Up-To-$15-Million Award." Hospitals and physicians are paying millions of dollars in awards to patients — for incidents some of which occured *up to 12 years ago.* Speculation is that these awards may be astronomical in the next decade.

As president of MPMLC, I am compelled to act upon information and to work with our board to implement procedures which will affect the physicians who have purchased the thousands of policies currently in force with our company.

Difficult decisions in the underwriting, claims, and actuarial areas sometimes are unpopular and criticized by our colleagues who may be adversely affected. In the exceedingly difficult economic times we all face in Michigan, it is distressing for physicians to see their professional liability premiums increase while their practice incomes diminish.

MPMLC instituted an overall, average 6 percent increase, the first rate increase in the history of the company, on July 1, 1982. The fact is that physicians insured with our company are still paying approximately 10 percent less for coverage in 1982 than they did in 1976. Other physicians have sought the least expensive alternative within the marketplace in terms of limits and the company they chose for professional liability insurance.

While these same physicians may be appropriately cutting costs within their practices, they certainly are taking a short-range posture within the medical-legal environment in our state. The cost of professional liability insurance is inexorably tied to the number of claims and amounts paid by each professional liability carrier. As these claims payments rise — so must premiums. Therefore, the competitive market which now exists in our state is a fragile one.

As an example, **Table 1** indicates the marked increase of claims reported to MPMLC by incident year. As of December, 1981 we had 258 claims reported on 1980 incidents. By November, 1982 that number had jumped to 622. Other years are facing sharp increases, as **Table 1** shows. The payment of these claims will come from premium dollars which were collected in past years. As these accelerating losses are reported and subsequently paid, an adjustment in rates for future claims is inevitable.

Reviewing our closed claims experience through December 1981, **Table 2** indicates that MPMLC is maintaining its strong stance in defending claims filed against its insured physicians. For incident year 1978, claims closed without payment equaled 72 percent — well above national figures for physician claims.

Our Claims Department is vigorously pursuing the closure of many files and we have added staff in that department throughout 1982. In fact, we are looking at projections which indicate that within five years the company could open 2,336 new

TABLE 1.
MPMLC EXPERIENCE BY YEAR INCIDENT OCCURRED

Incident Year	Report Year Claims 1976	1977	1978	1979	1980	1981	1982
1976	0	12	20	27	31	32	35
1977		39	108	190	243	262	275
1978			103	184	437	506	563
1979				39	169	468	582
1980					60	258	622
1981						94	350
1982							135

TABLE 2.
MPMLC CLOSED CLAIMS EXPERIENCE

Year	Claims Closed With Payment	Total Claims	Indemnity Paid	Expenses Paid
1976	6	22	138,500	66,171
1977	61	147	1,223,449	327,333
1978	45	162	1,062,859	207,787
1979	26	55	389,247	44,996
1980	13	23	110,592	12,561
1981	1	1	750	254

Doctor Leitch is president of MPMLC, as well as secretary of MSMS.

claims and have a total of 1,685 closed claims and 5,258 outstanding claims. These projections have prompted us to bolster our claim efforts and rapidly expand one of the finest claims staffs in the state.

Outstanding claims are a major concern of our company. **Table 3** depicts the multimillion dollar losses in incident years 1978 and 1979. Physicians should not be misled by the apparent peak in the average loss amount in 1978 since the "long-tail" effect of professional liability claims will increase that figure. Mounting losses coupled with the sharp increases in the volume of claims that are being handled by MPMLC do not offer much relief in the future.

Looking ahead to 1983, we would encourage physicians to review their policies for professional liability insurance with the emphasis on the "prudent buyer" concept. Professional liability is, in essence, a long-term commitment between the physician and his or her carrier. The survival of all companies in Michigan will be predicated upon strong leadership and excellent services to the members of each company. MPMLC has maintained its position of strength and financial viability without intervention or assistance from groups outside of our state. We have continued to offer insurance to all medical specialties, rather than rely on the selection of a high volume of low-risk physicians while shunning the other specialty groups.

Our success in the future will be directly tied to your support and the belief that MPMLC is the only, real solution to filling your need for professional liability insurance and other coverages for your practice. This belief is shared by physicians and medical staffs who call our company weekly to assist them in dealing with changes in hospital requirements such as mandatory professional liability coverage. The professional societies who look to MPMLC as the leader in Michigan have sought advice from our staff and we have developed many special research projects for their review.

1983 will continue to fester with adversity. Adversity between hospitals and their medical staffs . . . and cost caps by reimbursers adversely affecting physicians. New regulations stemming from the Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248) have proposed sweeping changes in the reimbursement of provider-based physicians. Many hospitals are requiring physicians who admit patients to their facilities to carry a minimum of $1 million professional liability coverage. This trend will continue. There is legislation pending dealing with professional liability problems. Although there may be hope in the possibility of tort reform, it could be years before measures are enacted which will mitigate the current situation.

I trust that members of the Michigan State Medical Society will join me and the thousands of MPMLC insured physicians who are supporting our company to effectively deal with these future areas of concern.

TABLE 3.
MPMLC OUTSTANDING CLAIMS EXPERIENCE

Year	Outstanding Claims	Indemnity Reserve	Expense Reserve	Average Size of Loss
1976	13	244,500	40,329	21,910
1977	115	3,316,542	408,249	32,390
1978	344	10,852,571	1,220,894	35,097
1979	413	11,333,364	1,578,990	31,265
1980	235	5,903,344	678,740	28,009
1981	93	2,311,609	197,349	26,978

CLOSED CLAIMS/*Continued*

Table XI
Claims Per Capita (Physicians)

Zip Code	Counties Included	Rate per 100 MDs
480	Macomb, Oakland, St. Clair	24
493	Kent, Lake, Mecosta, Montcalm	23
492	Calhoun, Hillsdale, Ingham, Jackson, Lenawee	22
489	Ingham	18
497	Alpena, Charlevoix, Cheboygan, Chippewa, Crawford, Emmett Luce, Mackinac, Montmorency, Otsego, Presque Isle	17
482	Wayne	16
496	Antrim, Benzie, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Osceola, Wexford	15
481	Livingston, Monroe, Oakland, Washtenaw, Wayne	15
490	Allegan, Barry, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren	14
494	Mason, Muskegon, Newaygo, Oceana, Ottawa	14
488	Clinton, Eaton, Gratiot, Ingham, Ionia, Isabella, Livingston, Shiawassee	14
484	Genesee, Huron, Lapeer, Oakland, Sanilac	14
485	Genesee	13
499	Baraga, Gogebic, Houghton, Iron, Keweenaw, Ontonagon	13
495	Kent	12
486	Arenac, Clare, Gladwin, Midland, Ogemaw, Oscoda, Roscommon, Saginaw	11
498	Alger, Delta, Dickinson, Marquette, Menominee, Schoolcraft	11
491	Berrien	5
487	Alcona, Bay, Iosco, Tuscola	4
	STATE TOTAL	17

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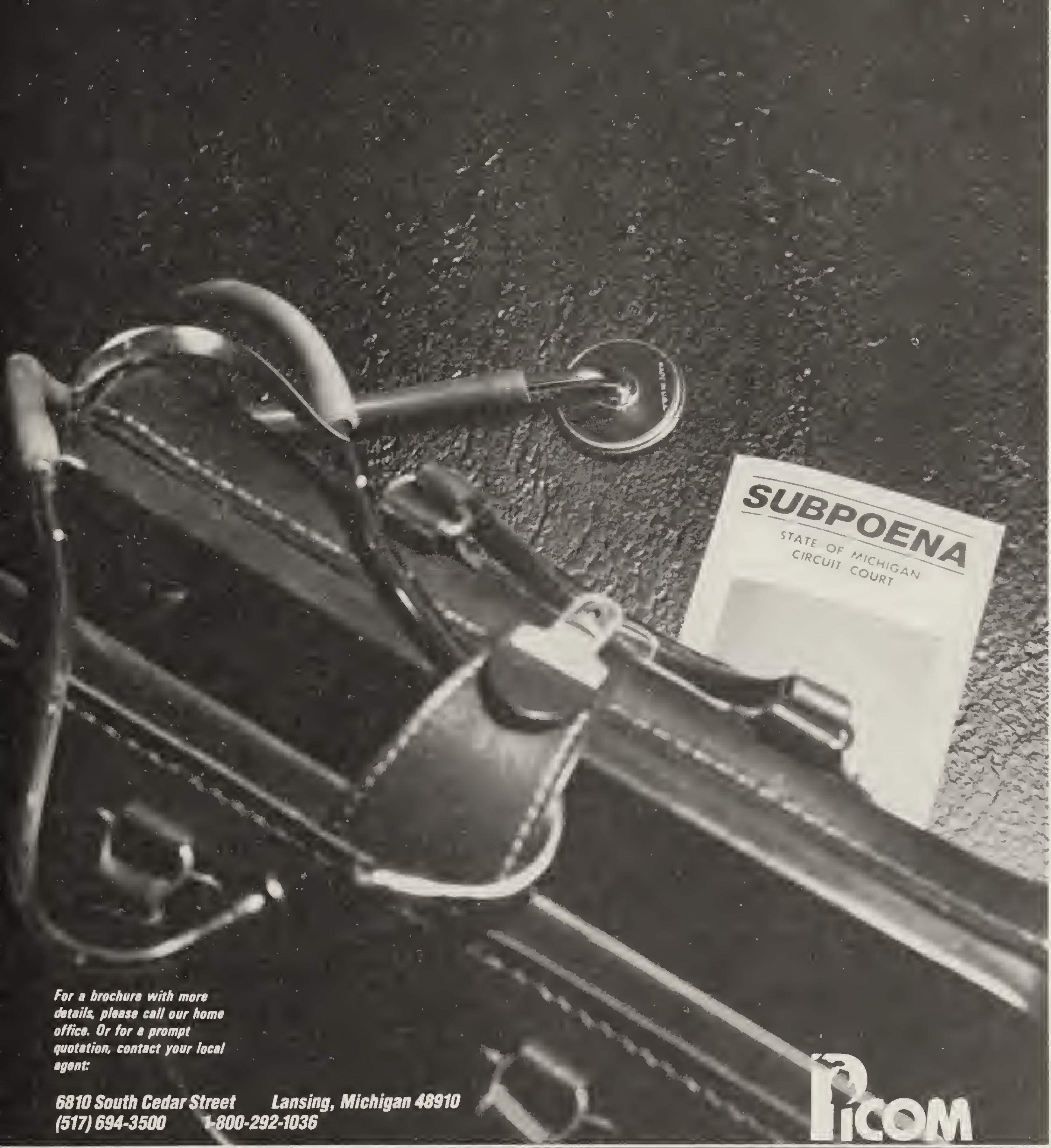

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Auxiliary's AMA-ERF fund-raising efforts gathering momentum

By Dorothy Csonka
Essexville

Michigan auxilians have contributed $6,949.50 to the American Medical Association Education and Research Foundation since June of this year. Nearly all of the donations have come with a designation for a specific medical school.

The word is getting around that these unrestricted funds are a convenient way to support an alma mater. Most schools in the 50 states, Puerto Rico, and Canada are eligible recipients. They find these funds fill a vital need for funding revolving loan funds, specialized equipment and programs and equipment not covered by federal, state, and other private grants.

Donors have three other options for the use of their AMA-ERF dollars. They can choose the *Loan Guarantee Fund* which still needs to maintain its loan reserves in spite of a temporary new loan suspension; the *Unrestricted Fund* which provides special grants for health and medical programs approved by the Foundation; and the *Categorical Research Fund* from which donors can specify research programs in the fields of neuro-muscular, metabolic, and endocrine diseases. Neoplastic, cardiovascular, pulmonary, arthritic, and rheumatic are also areas which can be designated.

An auction by Grand Traverse, Leelanau, and Benzie Counties, a lobster sale by Washtenaw County, and a Sharing Card program by Genesee County have provided the bulk of these early funds. By next May, most of Michigan's county Auxiliaries will have produced imaginative projects to multiply many times these early tools.

Mrs. Csonka is MSMS/A chairman for the AMA/ERF program.

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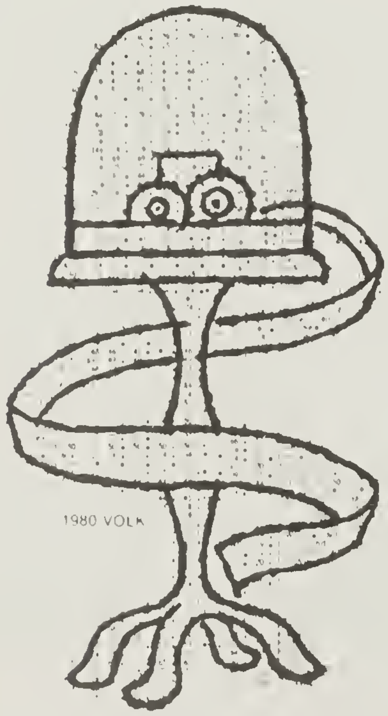
FINANCIAL PLANNING/
INVESTMENT PERSPECTIVES

Revised Alternative Minimum Tax requires careful tax planning

By Daniel Ludwin
East Lansing

Editor's note: With this article, *Michigan Medicine* continues a new series of articles to aid physicians in their personal financial planning. Author Daniel L. Ludwin welcomes MSMS members' questions on topics discussed in the articles. Mr. Ludwin will answer specific and unique questions directly, and will prepare further columns in response to questions which could be answered to the benefit of the general membership. Interested physicians may contact Mr. Ludwin by writing MSMS headquarters, 120 W. Saginaw St., East Lansing, 48823



Mr. Ludwin is senior vice president of Prescott, Ball and Turben, investment bankers and brokers, East Lansing. He is consultant to the MSMS Board of Managers on the investment of the MSMS capital and creative reserve funds assets. He has 15 years' experience in the financial field.

Ready or not, another new tax law, with some teeth in it, changes the rules for 1983 and beyond. With a wide variety of complex provisions (what's new?) the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) will require increased planning for most individuals.

While the 1981 tax act (ERTA) generally brought increasingly favorable treatment to individuals, TEFRA is basically detrimental. There are two major negative aspects of the new act. First, reduced retirement benefits for some corporate employees (which will be reviewed in a later article) and second, expanded application of the Alternative Minimum Tax (AMT).

New minimum tax rules

The AMT applies, in effect, when you have too much of a good thing. Such "good things" as intangible drilling cost deductions, rapid depreciation and depletion have previously been considered "preference" items and as such were subject to a special tax if excessive. The new law adds to the list of "preference" items such other "good things" as the 60 percent exclusion on long-term capital gains, the gain from employee incentive stock options and all-savers interest. After certain other adjustments, the alternative minimum taxable income is taxed at a flat rate of 20 percent. When your tax computed the AMT way, is greater than your tax computed the regular way, the *higher* tax must be paid!

Sheltering 20¢ dollars

The result is, that while an individual may be in a 50 percent marginal bracket for purposes of computing his "regular tax," if he is in an AMT situation, the additional tax deductions he takes will only reduce his taxes by the flat AMT rate of 20 percent! This *restructured* minimum tax (AMT) will require careful planning by taxpayers regarding how much and which of the available tax advantaged products to use.

1983 purposes

Tax preference items for AMT purposes in 1983 are:

- The deduction for long-term capital gains.
- Dividend income under the $100/200 exclusion, all-savers certificate interest, and interest excluded after 1984 under the 15 percent exclusion (a new preference item).
- Deductions for mining and exploration costs (other than on an oil or gas well), research and experimental costs, in excess of the amount that would have been deducted ratably over a 10-year period (a new preference item).
- Percentage depletion in excess of the adjusted basis of the property at the end of the tax year.
- Accelerated depreciation on real property or on personal property subject to a lease in excess of straight-line depreciation.
- Intangible drilling costs on oil, gas and geothermal wells in excess of the amount amortizable with respect to the cost, and in excess of net income from oil, gas and geothermal production.
- 60-month amortization of certified polution-control facilities in excess of the depreciation otherwise allowable.
- The "bargain element" at the time of exercise of an incentive stock option (ISO) (a new preference item).

Let's look at an example of how the tax works.

Suppose you are married, filing a joint return and your income and deductions look like this for 1982 and 1983:

	1982	1983
Salary	$ 30,000	$ 30,000
Long-term capital gain (Total = $100,000)	40,000	40,000
Tax shelter loss (all preference)	(25,000)	(25,000)
Adjusted gross income	$ 65,000	$ 65,000
Less: Itemized deductions:		
AMT itemized deductions	(10,000)	(10,000)
Other (net of zero bracket amount)	(5,000)	(5,000)
Taxable income (regular tax)	$ 50,000	$ 50,000
Plus: Shelter Preferences	$ -0-	$ 25,000
Bargain element of ISO	$ -0-	30,000
Capital gain exclusion	60,000	60,000
Alternative Minimum Taxable Income	$110,000	$165,000
Regular Tax	13,305	12,014
Alternative Minimum Tax	695	12,986
	$ 14,000	$ 25,000*
Add-on minimum tax (eliminated in '83)	2,250	NA
Total tax	$ 16,250	$ 25,000

(20% x $125,000)

All things being equal, under the revised AMT, total federal income tax would increase $8,750 in the above example. This is the result of the expanded list of tax preferences to include, in this case, certain tax shelter preference items and the bargain element of an incentive stock option (ISO).

To summarize, for tax years beginning with 1983, the new tax cut (TEFRA) repeals the add-on minimum tax, but significantly expands the alternative minimum tax (AMT). Additionally, the new law adds several new preference items to the list of 1983.

It is, however, apparent that with proper planning and monitoring, tax advantaged products can yield the same powerful deferral benefits as before the act was passed. It simply requires some additional caution.

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NEWS

By Debbie Lange
East Lansing

Doctor Bass

Doctor Bowman

Doctor Jensen

Doctor Krause

Charles K. Krause, MD, was elected to a three year term on the board of directors of the American Academy of Otolaryngology. He is professor and chairman of otorhinolaryngology at University of Michigan Hospitals in Ann Arbor. Doctor Krause is immediate past-president of the American Academy of Facial Plastic and Reconstructive Surgery and chairman of the American College of Surgeons' Advisory Council for Otolaryngology. . . . New president of the Civil Aviation Medical Association is **William J. Jones, MD,** an Allen Park, Michigan pediatrician. Doctor Jones has been a senior medical examiner for the Federal Aviation Administration since 1960. . . . The Transplantation Society of Michigan has elected four physicians by acclamation to its Board of Trustees. They are **Robert D. Allaben, MD,** Vice Chief of Staff and vice chief of surgery at Harper-Grace Hospital, Detroit; **Larry Robson, MD,** a specialist in vascular surgery, affiliated with Blodgett Memorial Medical Center and St. Mary's Hospital, both in Grand Rapids; **J. C. Rosenberg, MD, PhD,** chief of surgery at Hutzel Hospital, Detroit, a founding member of the TSM, and long-time TSM trustee, and **Luis H. Toledo-Pereyra, MD, MS, PhD,** chief of the Section of Transplantation and director of surgical research at Mt. Carmel Mercy Hospital, Detroit. . . . **Vernon V. Bass, MD,** was elected president of the Michigan Association of the Professions at its 23rd Annual Congress. . . . **Thomas Petz, MD,** of St. Clair Shores, chief of the Harper-Grace Hospitals section of pulmonary medicine is new president of the Detroit Academy of Medicine. **Raymond Bauer, MD,** of Grosse Pointe Park, Harper-Grace vice chief of neurology, was elected president-elect, and **John Schneider, MD,** St. Clair Shores oncologist, was elected secretary treasurer of the academy. . . . **H. Gunter Seydel, MD,** has been appointed chairman of Therapeutic Radiology at Henry Ford Hospital. Formerly, Doctor Seydel was director of Clinical Radiation Therapy at Harper-Grace Hospitals' Radiation Oncology Center. . . . **Wil-B. Jensen, Jr., MD,** Grand Rapids, has been re-elected vice-speaker of the House of Delegates of the 18,000 member American Society of Anesthesiologists. He is a member of the attending staff in anesthesiology, Butterworth Hospital, Grand Rapids, and clinical professor of anesthesiology, Michigan State University, Grand Rapids. . . . The AMA Board of Trustees recommended for reappointment the following for two-years terms: **Roy J. Gerard, MD,** East Lansing, for Residency Review Committee for Family Practice; **Edward R. Powsner, MD,** Detroit, for RRC for nuclear medicine; **Robert Pool, MD,** Birmingham, for RRC for plastic surgery; and **Jeremiah G. Turcotte, MD,** Ann Arbor, for RRC for surgery. . . . **Vernon Urich, MD,** chief of urology at St. Joseph Hospital, was given an award for "outstanding" exhibition at the recent annual conference of the American Academy of Family Practice in San Francisco. The exhibit, "What Men Know About Prostate Cancer," also received an award from the American Urological Association. . . . Two Lansing area physicians have been elected to head the Medical Scientific Advisory Committee for the Mid-Michigan Chapter of the American Red Cross. **Laurence R. Simpson Jr., MD,** was elected committee chairman. He is chief of medical staff at Sparrow Hospital and co-director of the hospital's laboratories. **Kenneth R. Wilcox, MD,** was elected committee vice chairman. He is chief of the Michigan Department of Public Health Bureau of Disease Control and Laboratory Services. . . . **Peter A. Duhamel, MD,** Rochester surgeon, is new president of the Oakland County Medical Society (OCMS). Doctor Duhamel has been in private practice of general surgery in Oakland County since 1963. OCMS President-elect is **Gerald F. Conway, MD,** urologist . . . Two MSMS members were elected to the board of directors of the Council of Medical Specialty Societies (CMSS) at their annual meeting. **William C. Montgomery, MD,** Detroit, is a representative to the CMSS from the American Academy of Pediatrics (AAP) and was elected to the CMSS Board of Directors in 1982. **Douglass A. Haddock, MD,** Kalamazoo, is a representative to the CMSS from the American Academy of Family Physicians. . . . **William Martel, MD,** is new chairman of the University of Michigan department of radiology. He has served as acting chairman since 1981. . . . **Harold E. Bowman, MD,** director of laboratories at St. Lawrence Hospital, has been elected to a three-year term as a governor of the College of American Pathologists. Doctor Bowman is professor and associate chairman of the Department of Pathology at Michigan State University. . . . Friday, Oct. 15, was designated **"Dr. Joseph Bertucci Day"** at Bell Memorial Hospital to honor the memory of the Ishpeming physician and cardiologist who served the area for nearly 50 years before his death on Oct. 15, 1980.

Doctor Bergman

Doctor Canady

Clarification

The persons here were pictured in the December issue of *Michigan Medicine*, but unidentified. They are Roy T. Bergman, MD, Escanaba, left, recipient of a Distinguished Service Award from the National Federation of Interscholastic Officials; and Alexa Canady, MD, Detroit, new director of pediatric neurosurgery at Henry Ford Hospital.

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Bactrim™ attacks the
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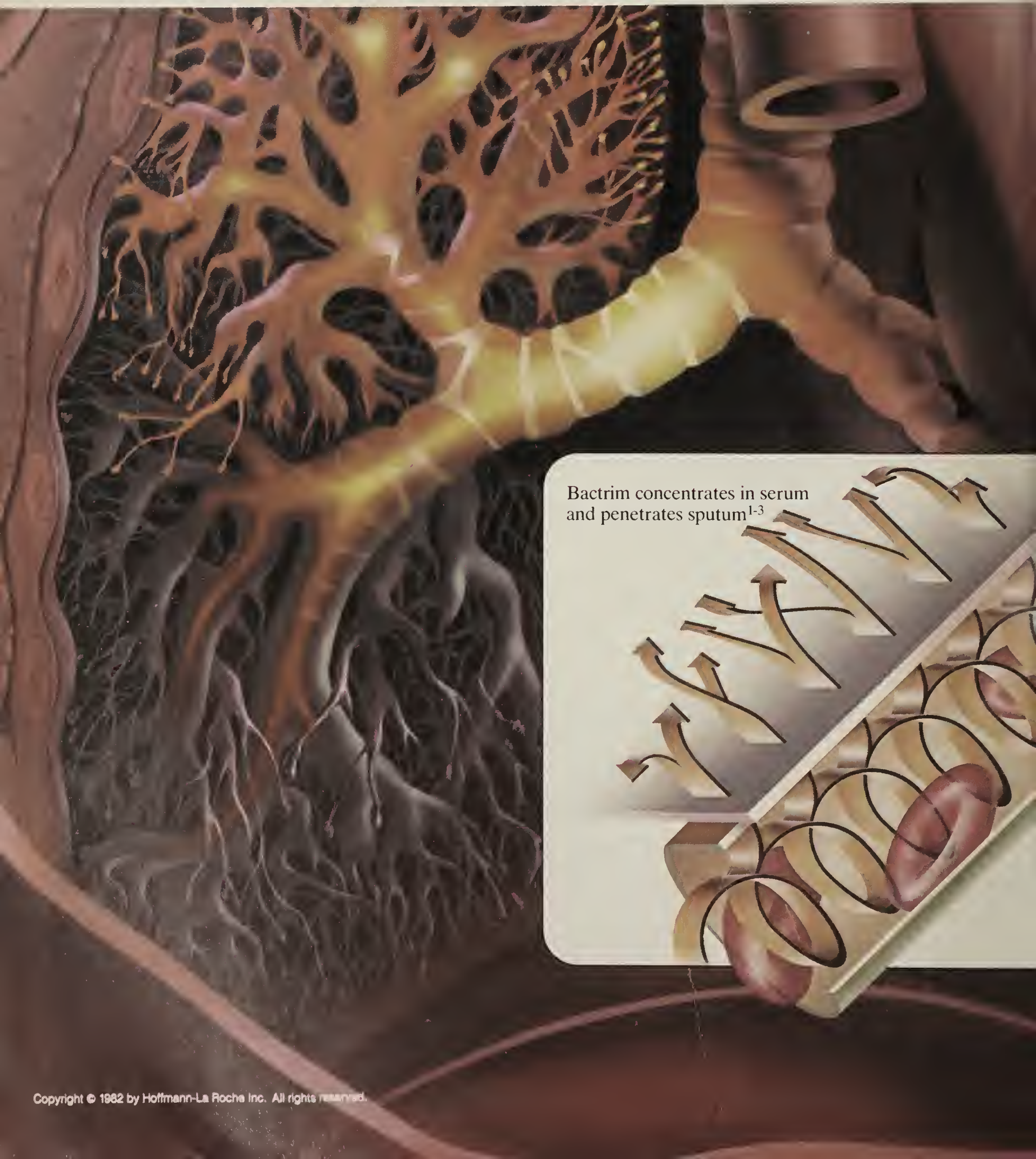
in acute exacerbations



Bactrim concentrates in serum and penetrates sputum[1-3]

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ROCHE®

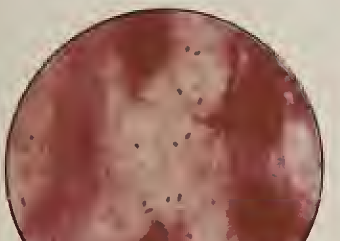
major pathogens of chronic bronchitis*

Bactrim clears sputum of susceptible bacteria

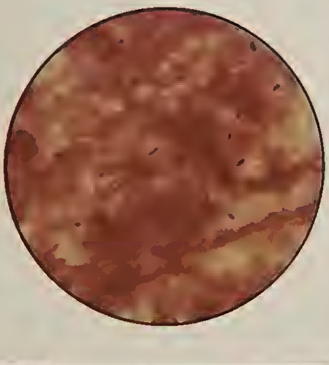
In sputum cultures from patients with acute exacerbations of chronic bronchitis, *H. influenzae* and *S. pneumoniae* are isolated more often than any other pathogens.[4,5] One study of transtracheal aspirates from 76 patients with acute exacerbations found that 80% of the isolates were of these two pathogens.[5]

Bactrim is effective *in vitro* against most strains of both *S. pneumoniae* and *H. influenzae*—even ampicillin-resistant strains. And in acute exacerbations of chronic bronchitis involving these two pathogens, sputum cultures taken seven days after a two-week course of therapy showed that Bactrim eradicated these bacteria in 91% (50 of 55) of the patients treated.[6]

attacks *H. influenzae*—even ampicillin-resistant strains



attacks *S. pneumoniae*



Bactrim reduces coughing and sputum production

In three double-blind comparisons with ampicillin *q.i.d.*, Bactrim DS proved equally effective on all clinical parameters.[7-9] Bactrim reduced the frequency and severity of coughing, reduced the amount of sputum produced and cleared the sputum of purulence.

Bactrim has the added advantages of *b.i.d.* dosage convenience and a lower incidence of diarrhea than with ampicillin, and it is useful in patients allergic to penicillins.

Bactrim also proved more effective than tetracyclines in 10 clinical trials involving nearly 700 patients.[10] Overall clinical condition of the patients, changes in sputum purulence, reduction in sputum volume and microbiological clearance of pathogens—all improved more with Bactrim therapy than with tetracyclines. G.I. side effects occurred in only 7% of patients treated with Bactrim compared with 12% of tetracycline-treated patients. (See Adverse Reactions in summary of product information on next page.)

Bactrim is contraindicated in pregnancy at term and nursing mothers, infants under two months of age, documented megaloblastic anemia due to folate deficiency and hypersensitivity.

Bactrim DS. For acute exacerbations of chronic bronchitis in adults* when it offers an advantage over single-agent antibacterials.

References: **1.** Hughes DTD, Bye A, Hodder P: *Adv Antimicrob Antineoplastic Chemother 1/2*:1105-1106, 1971. **2.** Jordan GW *et al: Can Med Assoc J 112*:91S-95S, Jun 14, 1975. **3.** Beck H, Pechere JC: *Prog Antimicrob Anticancer Chemother 1*:663-667, 1969. **4.** Quintiliani R: Microbiological and therapeutic considerations in exacerbations of chronic bronchitis, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts;* Princeton Junction, NJ, Communications Media for Education, Inc., 1980, pp. 9-12.
5. Schreiner A *et al: Infection* 6(2):54-56, 1978. **6.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **7.** Chodosh S: Treatment of acute exacerbations of chronic bronchitis: results of a double-blind crossover clinical trial, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts. Op. cit.*, pp. 15-16. **8.** Chervinsky P: Double-blind clinical comparisons between trimethoprim-sulfamethoxazole (Bactrim™) and ampicillin in the treatment of bronchitic exacerbations. *Ibid.*, pp. 17-18. **9.** Dulfano MJ: Trimethoprim-sulfamethoxazole vs. ampicillin in the treatment of exacerbations of chronic bronchitis. *Ibid.*, pp. 19-20. **10.** Medici TC: Trimethoprim-sulfamethoxazole (Bactrim™) in treating acute exacerbations of chronic bronchitis: summary of European clinical experience. *Ibid.*, pp. 13-14.

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b.i.d.

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole/Roche)

*Due to susceptible organisms. **Please see next page for summary of product information.**

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Bactrim™

(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia *Allergic reactions.* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN

Adults. Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i d for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children. Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment. Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS.

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b i d for 14 days.

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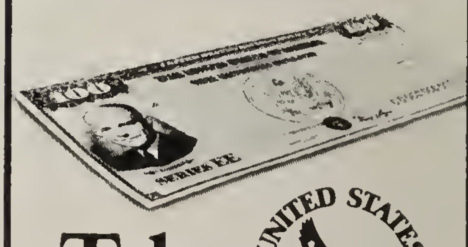

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MEDICO-LEGAL

MSMS Legal Counsel A. Stewart Kerr provides the following memoranda on recent legal cases of interest to Michigan physicians.

Rule of Reason

The U.S. Court of Appeals, 4th Circuit, made some interesting pronouncements in October in a health care case *(Hospital Building Co.* v *Trustees of Rex Hospital).*

If a plaintiff makes out a *prima facie* case by showing acts that, but for health care planning legislation, would constitute a *per se* violation of the Sherman Act, the defendants can raise the affirmative defense of reasonableness of the planning activities.

The Court said that the planning activities of private health service providers can be judged under a special rule, a "very narrow rule of reason." Those planning activities are not unreasonable restraints of trade if undertaken in good faith and if their actual intended effects are within those envisioned by specific (federal) legislation.

The Court reviewed federal and state (North Carolina) statutes encouraging state and local health care planning; it found the oversupply of health services and maldistribution of in-patient health care facilities are roadblocks to a more cost-effective operation of the health services market.

These laws do not provide express antitrust exemption or mandate participation by local health providers, but this Court believes that such participation is quite desirable and therefore the Court adopted this "very narrow rule of reason."

Analogies are always dangerous. This decision does not by any means place the stamp of approval on any and all health care activities that Michigan groups might want to put into effect. Further, the final judgments in the *AMA* and *ADA* cases have to be considered. Yet the 4th Circuit remarks offer encouragement. And the case is certainly citable in the event of any real or threatened Michigan antitrust litigation against health providers who are working together to achieve cost containment.

Association membership

The U.S. Supreme Court has refused to hear the case, *Boddicker* v *Arizona State, Central Arizona and American Dental Associations,* leaving the Ninth Circuit Court of Appeals' decision in place.

You may find this of interest because of its obvious medical society implications.

The Ninth Circuit ruling is now the final word: a membership rule of the three Arizona dental associations requiring dentists to belong to the national organization in order to have membership in local associations does not violate the Sherman Act.

That association rule is not a per se illegal tying arrangement and there was no showing that the rule suppressed competition between dentists.

Moreover, the associations had not monopolized Arizona dentistry as the organizations do not practice dentistry and membership in them is not a precondition for a state license.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D., R. Witherington, M.D., I. B. Sipahioglu, M.D. Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only

Additional Indications: Replacement therapy When androgen deficiency is the cause of: male climacteric/eunuchoidism, eunuchism/post-puberal cyptorchidism.

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Physicians must compete on economic as well as political levels

By Paul Feldstein, PhD
Ann Arbor

Doctor Feldstein

The following article is prepared from an analysis of economic trends in health care presented at the 1982 MSMS Public Affairs/Leadership Conference Oct. 28 in Lansing. A transcript of Doctor Feldstein's talk has been prepared and is available to interested physicians in full. Copies may be obtained by contacting Kevin Kelly or William Madigan at MSMS headquarters.

Those very factors that once served to stimulate demand for health care now are serving to decrease demand.

In addition, the changing market in which hospitals and physicians are competing is making it even more difficult to offset those demand increases.

The main implication for physicians is that unless these changing trends are recognized on both the demand and supply sides, and unless appropriate actions are taken, physicians' incomes and their role in society will be greatly diminished in the years ahead.

Doctor Feldstein is an economist with the University of Michigan.

To sum from the demand side:

Things look relatively bleak as far as federal and state funds are concerned, as the main role of the federal government today is cost containment. The government is working to cut back on Medicare and Medicaid.

But they are afraid, then, that the participation rate, the assignment rate, will go down. So there has been some talk of making Medicare assignment mandatory or of going to a voucher system for the aged. State governments and businesses also are looking at preferred provider organizations to cut back on costs.

An important implication for physicians in all of this is that it locks in patient population. The trend is away from free choice of physician.

The supply side also looks relatively difficult. What's going to happen is there's going to be a great deal more conflict. Whenever there is a smaller pie to share, or fewer resources, you're going to find more conflict. The hospitals that you're part of are going to be in conflict externally with the insurance companies, with the government, with HMOs. Internally, in the hospital, there's going to be a great deal of conflict between physicians, nurses and non-physician substitues over expanded roles.

In order for an institution or an organization to compete successfully, externally, it's going to have to resolve internal conflicts. And I think physicians, medical staff, and hospitals are going to have to work out the necessary internal changes in order for their organizations to survive and compete through the years ahead.

Political action

Now, given this bleak outlook, what are the choices physicians face? I think there are two, not mutually exclusive.

The first is increased political action. I should say first that I don't think it's possible to maintain the status quo. Therefore, we have to see what can be done.

An example of this is political action over the state practice act to protect your own turf. Registered nurses are trying to increase their qualifications in becoming a nurse. They propose that every nurse have, by 1985, a baccalaureate degree. That means the supply of registered nurses would increase by only one-third, since only one-third of the graduating nurses have a BA degree. The effect of this will be to limit the number of nurses (this may raise the cost of hospital care) and to prepare them for new tasks in competition with physicians. So, there's going to be political action necessary at the state level.

But I don't think political action by itself can really withhold the economic trends. And I don't think you're going to be able to withhold the big increase in supply of physicians or the greater competition among physicians, HMO's and multisystems.

Must compete

So, you have to have another strategy as well. That strategy is to compete — in an economic sense. What that means is that physicians will have to become aware of the economic trends. I think they have to decide to go with those trends, that they can't just hang back and wait. They won't be able to stop them. Therefore, they're going to have to do something about them.

Now, physicians are the most knowledgeable purchasers in the market. They have that advantage to start with. It would be better if physicians could make their own decisions on their practice, and on how to conserve premium dollars, rather than leaving them to the people in Washington or by becoming part of a larger organization where the physician has less autonomy.

Four strategies

Now, if physicians are going to decide to compete economically then

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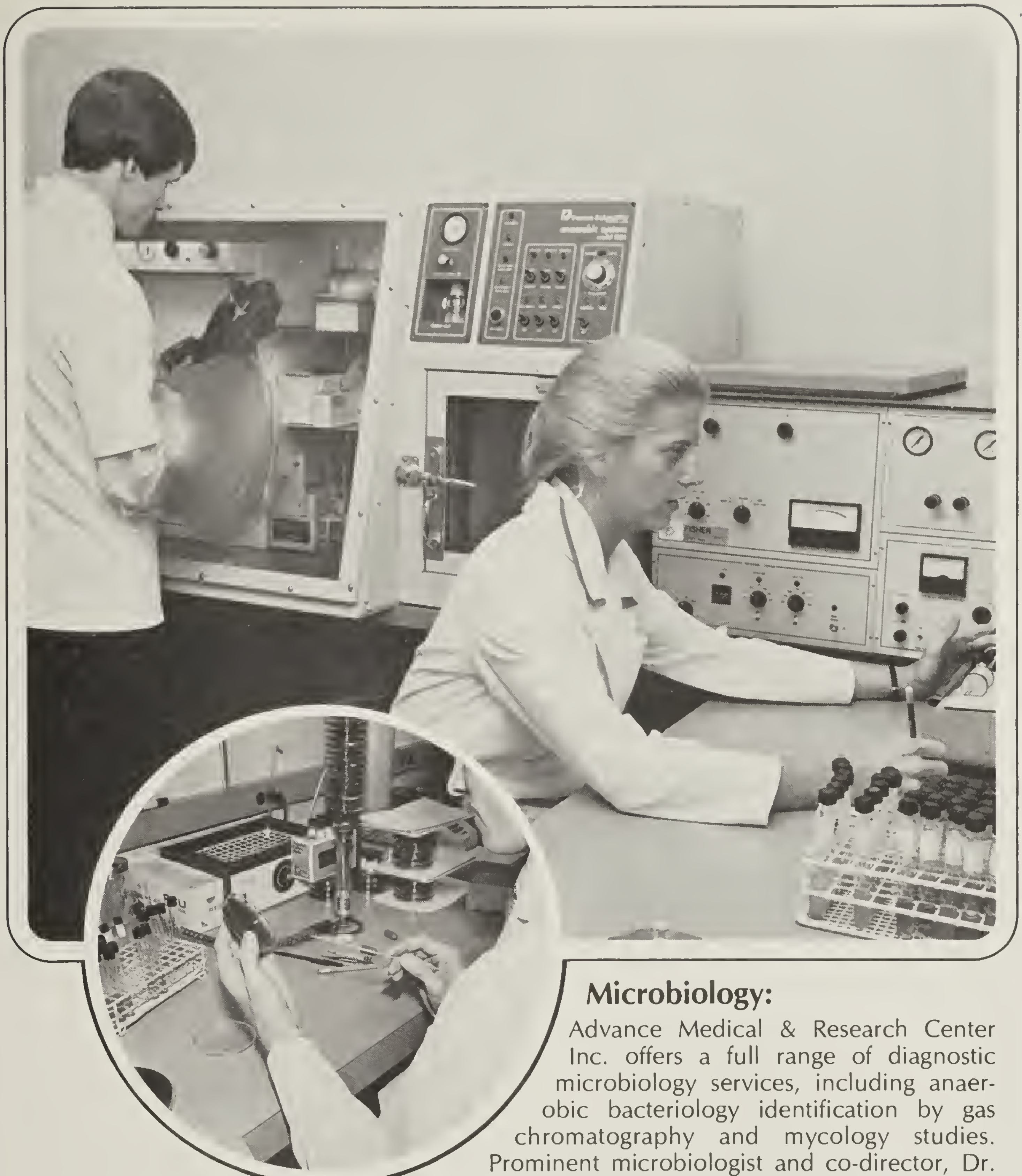

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the question is how. I think there are four things that physicians should look into.

1) The first is new services and new markets. One of the fastest growing population markets in this country is the aged. In 1970 the aged grew by 28 percent compared to 11 percent for the entire population. Over the 1980s, the aged again are going to be a fast growing group. And one of the fastest growing segments of the aged is those over 75 years of age. So, the aged are a large market; the aged will have funds. More funds will be available from the aged themselves and by others who pay for out-of-hospital care. The aged need more than acute services; they have a lot of needs. I think if physicians don't move into this market, they will find nurses and other practitioners very willing to move in.

2) Another strategy is to find out more about preferred provider organizations. As there's excess capacity in an area, and as there's more interest in cost containment, I think businesses will be shopping around for better deals. I think insurance companies, as in Denver, will be trying to put together preferred provider organizations. If physicians don't find out about PPOs and begin to think about how they can organize for them, I think they'll find others are.

3) The third strategy is to find out more about HMOs and to consider them more seriously. What you find is that HMOs make their savings by cutting hospital utilization rates in half. The percent of the health care dollar going to hospitals under an HMO is much smaller than under the fee for service system. So, physicians looking for new sources of revenue and getting part of those savings for themselves will seriously consider how they can establish HMOs and/or become part of HMOs.

4) The last strategy is with respect to Blue Cross Blue Shield of Michigan. BCBSM has such a large market share that it's a dominant payer. If you wait to see what Blue Cross is going to do, then the likely outcome will be much tighter on reimbursement. Your revenues will be severely constricted and you'll have very little choice because you'll be locked into Blue Cross and Blue Shield.

I think what Michigan State Medical Society has to do is to think of alternatives to Blue Cross Blue Shield. One way is to think in terms of competitive plans; the best strategy for a provider is to have competition on the payer side. To the extent that you can develop such competition among the Blues and other companies, you'll be much better off than you would be by just being part of the Blues with their very large market share.

I think physicians have to be involved politically to protect their own interest. But I don't think they can rely totally on the political process to maintain their incomes and their revenues. I think what physicians also have to look at is the market competition; because I think in the long run you'll find that the rewards are much fairer and the outcome is much better through economic competition rather than just political competition.

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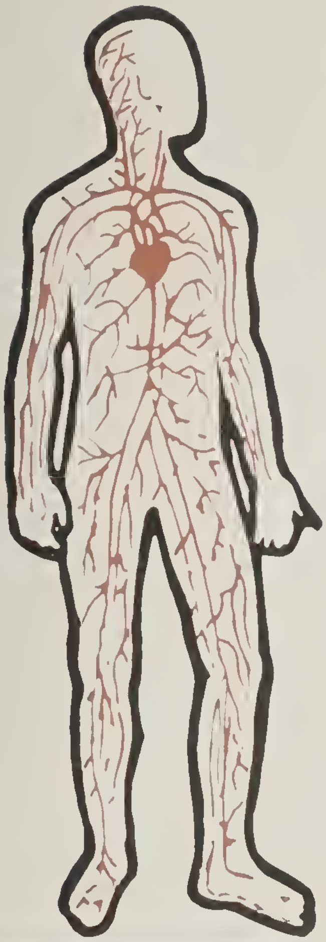

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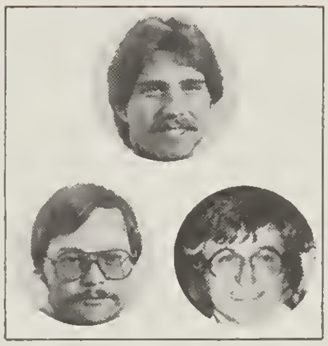

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Board of Medicine disciplinary actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are summarized below by MSMS legal counsel from official memoranda to MSMS. Any subsequent actions of the board will be printed in future issues.

- **DOMINIC J. MARTINETTI, MD**

327 Silver St.
Hurley, WI 54534

Date, action taken
October 13,1982
Reprimand; Limited license

Violation

Allegations concerning the handling of an obstetrical patient in 1980 are neither admitted nor denied. The doctor consented to a limited license which precludes practice of obstetrics or gynecology and precludes personal performance of major surgery.

- **PETER NOWOSIELSKI, MD**

30245 Harper
St. Clair Shores 48082

Date, action taken
Oct. 13, 1982
Reprimand, by consent

Violation
Facts not known

- **ROBERT RIVAS CANAS, MD**

406 N. Saginaw St.
Durand 48429

Date, action taken
September 14, 1982
Three (3) year probation, by consent

Violation

Controlled substances violation. Controlled substance license surrendered for twelve (12) months, during which time he may not obtain, possess, prescribe, dispense or administer any controlled substance. For the second (2nd) and third (3rd) years, Doctor Canas must maintain a separate log of all controlled substances, listing date, dosage and reason for use of controlled substances, with patients' names masked. This log shall be separate from regular patient records and shall be subject to periodic inspection by the Board.

- **ARCADIO P. BUSTILLO, MD**

215 N. Kalamazoo St.
Paw Paw, 49079

Date, action taken
October 13, 1982
One (1) year probation, by consent

Violation

Dilaudid was prescribed for a bilateral amputee nine (9) times in substantial quantities, until Dr. Bustillo ultimately refused further prescriptions. There were extenuating circumstances but the doctor concedes that he may have acted below minimal standards and that he failed to exercise due care.

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MEETINGS

MSMS, MSMS/A, AMA, and medical assistants

Jan. 19 — MSMS Council, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Feb. 7 — MSMS/A Mid-Year Board Meeting, MSMS headquarters, contact: Caroline Rich, 517/337-1351 (Feb. 14 snow day).

March 2 — MSMS Council, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

March 23 — MSMS Conference for Women Physicians, MSMS headquarters, contact: Sherry Fent, 517/337-1351.

April 6 & 7 — Michigan Conference on Maternal & Perinatal Health, Grand Center, Grand Rapids, contact: Katie Brewbaker, MSMS headquarters.

April 29-May 1 — MSMS House of Delegates, Hyatt Regency, Dearborn, contact: Richard Campau, 517/337-1351.

May 2-3-4 — MSMS/A 57th Annual Convention, Holiday Inn, Jackson, contact: Caroline Rich, 517/337-1351.

June 18-23 — Annual Meeting of the AMA House of Delegates, Marriott Hotel, Chicago, contact: Bruce Ambrose, MSMS headquarters.

June 19-22 — AMA Auxiliary Convention, The Drake Hotel, Chicago, IL, contact: Caroline Rich, 517/337-1351.

July 21-24 — MSMS Council Midsummer Meeting, Deer Lake, Boyne Mountain, contact: Warren F. Tryloff, MSMS headquarters.

Sept. 14 — MSMS Council Meeting (Rescheduled from Sept. 21 to Sept. 14), MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Nov. 23 — MSMS Council, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Other Meetings

Jan. 21 — The University of Michigan, A conference on "Health Issues of Women in the Workplace," U-M Chrysler Center, Ann Arbor, contact: U-M School of Public Health, Center for Continuing Education, 313/764-8093 or write to Center at Rm. 3512 SPH I, the U-M, Ann Arbor 48109.

Feb. 8 — American Medical Women's Association, Inc., Debbie Stabenow speaking on "Legislative issues affecting women's health," MSMS headquarters, contact: Shirley J. Robertson K, MD, or Dawn E. Springer, MD, 517/676-9066, or write 230 Temple St., Mason 48854.

May 26 — Southwestern Michigan Perinatal Association "Perinatal Potpourri," Western Michigan University, Kalamazoo, contact: Karen Riley, RN, OB Education Coordinator, Memorial Hospital, 2611 Morton Ave., St. Joseph 49085, 616/983-8171.

Sept. 6-10 — Association for the Advancement of Medical Instrumentation (AAMI) 1983 Regional Meeting, Detroit, interested participants/cosponsors for 1983 or 1984 meetings should contact: Renee Pietrangelo, AAMI national office, 703/525-4890.

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Prostacyclin Treatment of Patients with End-Stage Arterial Disease

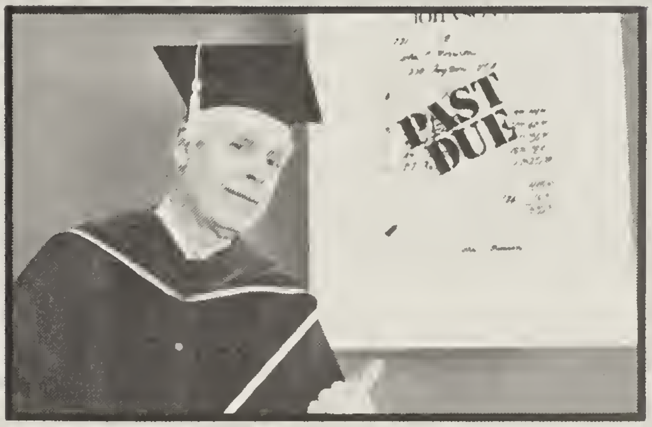
Prostacyclin (PGI_2) is a recently discovered prostaglandin normally produced by vascular endothelium. It is the strongest vasodilating agent and most potent inhibitor of platelet aggregation currently known. Because of these characteristics, it has been used in European studies as a therapeutic agent in patients with end-stage atherosclerotic arterial occlusive disease. Good results have been reported in approximately half of those patients with rest pain or arterial ulcers.

The present study is a blinded, placebo-controlled investigation of the therapeutic effect of intravenous PGI_2 in patients with unreconstructible arterial disease who have rest pain or ulceration.

Patients with ulcers larger than 25cm^2 or patients with significant infection or gangrene requiring urgent amputation are excluded. Both diabetic and non-diabetic patients are eligible, but ulcers must have been present and stable for at least three weeks. Specific exclusion criteria for this study are patients unable to sign informed consent, women of child-bearing age, recent CVA or MI, bleeding disorders, malignancy, or other acute medical problem.

Patients are treated in the Clinical Research Unit at the University of Michigan Hospitals, where they receive a 72-hour infusion of PGI_2 or placebo. Non-invasive vascular studies, xenon muscle-bloodflow measurement, and platelet function tests are performed during and after drug administration. Patients who have failed to demonstrate objective improvement are eligible for a second infusion, which constitutes a separate segment of this study. At that time, all patients recieve active PGI_2. Patients must return for monthly follow-up for six months.

This study has been approved by the Human Studies Committee at the University of Michigan. To date, no side effects have occurred. Costs specific to drug treatment or research testing are funded by the research grant. Contact: Jack L. Cronenwett, MD, Department of Surgery, 2215 Fuller Road, Ann Arbor, 313/769-7100.



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CATEGORY I COURSES

***Michigan Medicine* each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517)337-1351.

Date: January 17-20, Current Cardiovascular Therapeutics — 1983. Location: Boyne Mountain Ski Lodge. **Sponsor:** Michigan Heart Association. **Cost:** $75. After January 4, $80. **Contact:** Eleanor D. Peterson, RN, Michigan Heart Association, 16310 West Twelve Mile Rd., PO Box 160-LV, Lathrup Village, 48076. **Approved for:** 14 hours of Category I Credit.

Date: January 19, Rheumatology Day II. Location: Saint John Hospital, 22101 Moross Rd., Detroit, 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Internal Medicine. **Cost:** Saint John Hospital Staff, $75; River District Hospital Staff, $75; Other Physicians, $100. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: January 21, Health Issues of Women in the Workplace. Location: University of Michigan, Ann Arbor. **Sponsor:** The School of Public Health, Center for Continuing Education, and The Center for Occupational Health and Safety Engineering, The University of Michigan. **Cost:** $125. **Contact:** The Center for Continuing Education, Attn.: John Woodford, School of Public Health, Rm. 3512, The University of Michigan, Ann Arbor, 48109, (313) 764-8093. **Approved for:** 5.5 hours of Category I Credit.

Date: Jan. 30-Feb. 4, Seventh Annual Midwinter Family Practice Update. Location: Boyne Highlands, Harbor Springs. **Sponsor:** Office of CME, U-M Medical School. **For:** Family practitioners. **Cost:** $335 - practicing physician fee; $265 - physician-in-training fee; $85 - single day attendance. **Contact:** Office of CME, Towsley Center, Box 057, U-M Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 21 hours of Category I Credit.

Date: February 12, "Therapeutic Drug Monitoring." Location: Henry Ford Hospital, Detroit. **Sponsor:** Michigan Society of Pathologists. **For:** Pathologists. **Contact:** Willys F. Mueller, MD, Dept. of Pathology, Hurley Hospital, Flint. **Approved for:** 3 hours of Category I Credit.

Date: February 13-18, The Eighth Annual Seminar on Emergencies in Medicine. Location: Boyne Highlands, Harbor Springs. **Sponsor:** Wayne State University School of Medicine, Michigan Committee on Trauma, and Society of Critical Care Medicine. **Cost:** $50. **Contact:** Theresa Sokol, Dept. of Surgery, WSU, 6-C University Health Center, 420 St. Antoine, Detroit 48201 (313) 577-5009. **Approved for:** 22 hours of Category I Credit.

Date: February 14-18, Trauma: The First Three Hours. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, The Section of Emergency Medicine and The Department of Surgery. **Cost:** $475 Physician course fee; $300 Animal Laboratory fee. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 37 hours of Category I Credit.

Date: February 18-19, Practical Otolaryngology. Location: Michigan Inn, Southfield. **Sponsor:** Wayne State University School of Medicine, Department of Otolaryngology. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 4201 St. Antoine, 4H UHC, Detroit, 48201 (313) 577-1180. **Approved for:** 12 hours of Category I Credit.

Date: February 18-20, Advanced Trauma Life Support. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, The Section of Emergency Medicine, and The Department of Surgery. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor, 48109 (313) 763-1400. **Approved for:** 18 hours of Category I Credit.

Date: March 23, New Technology And Instrumentation In Obstetrics And Gynecology. Location: Saint John Hospital, 22101 Moross Rd., Detroit, 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Obstetrics & gynecology. **Cost:** Saint John Hospital Staff - $75; River District Hospital Staff - $75; Other Physicians - $100. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education, (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: March 26-27, Rheumatology Seminar. Location: Sheraton-Southfield Hotel, Southfield. **Sponsor:** Wayne State University School of Medicine, Division of Rheumatology. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 4201 St. Antoine, 4H UHC, Detroit, 48201 (313) 577-1180. **Approved for:** 9.5 hours of Category I Credit.

Date: March 30, Selected Topics in Oral Cavity Carcinoma — A Practical Approach. Location: Sheraton-Southfield Hotel, Southfield. **Sponsor:** Wayne State University School of Medicine, Department of Otolaryngology. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 4201 St. Antoine, 4H UHC, Detroit, 48201 (313) 577-1180. **Approved for:** 8 hours of Category I Credit.

Date: April 8-10, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, MSU, East Lansing. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: April 20, Pediatric Acute Care. Location: Saint John Hospital, 22101 Moross Rd., Detroit 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Pediatric. **Cost:** Saint John Hospital Staff - $75; River District Hospital Staff - $75; Other Physicians - $100. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education, (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: May 18, Inflammatory Bowel Disease. Location: Saint John Hospital, 22101 Moross Rd., Detroit 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Surgery. **Cost:** Saint John Hospital Staff - $75; River District Hospital Staff - $75; Other Physicians - $100. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education, (313) 343-4877. **Approved for:** 8 hours of Category I Credit.

Date: June 13-17, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Medicine, MSU, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine, Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48823 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: June 15, Geriatrics and Family Practice, Medical and Ethical Decision Making. Location: Saint John Hospital, 22101 Moross Rd., Detroit 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Family Practice. **Cost:** Saint John Hospital Staff - $75; River District Hospital Staff - $75; Other Physicians - $100. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education, (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: June 21-23, Real-time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: Nov. 1-3, 1983, Real-time Ultrasound Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: May 22-24, 1984, Real-time Ultrasound Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

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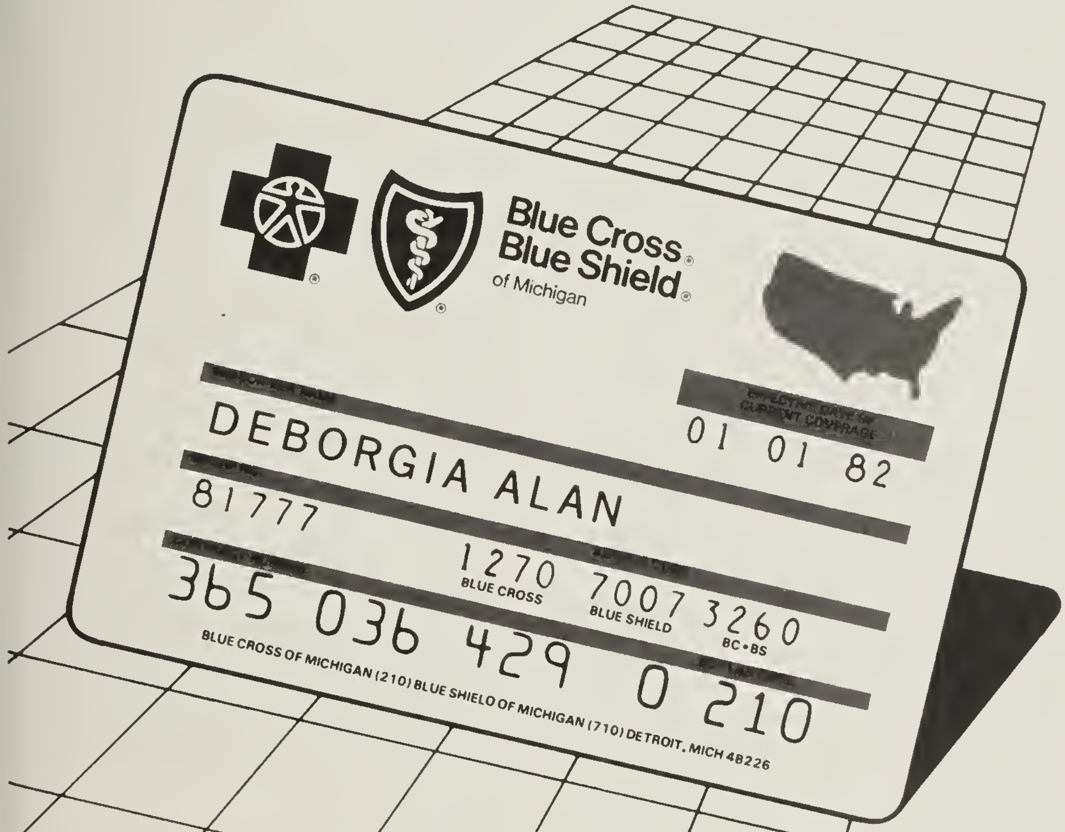

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DEATHS

Luther C. Carpenter, MD
Grand Rapids

Luther C. Carpenter, MD, Grand Rapids, died October 27. He was 76. Doctor Carpenter graduated from the University of Michigan Medical School in 1932 and established his residency at University Hospital in Ann Arbor. He practiced in Grand Rapids from 1938 until retirement in 1978. Doctor Carpenter served as a Lt. Col. in the Army Medical Corps during WWII and was a member of many medical societies including the American College of Surgeons and the American Board of Surgery. He also was affiliated with Blodgett Memorial, St. Mary's, and Butterworth Hospitals, all of Grand Rapids.

Edmund J. Dudzinski, MD
New Baltimore

Edmund J. Dudzinski, MD, of New Baltimore died November 13. He was 75. He was a medical doctor in New Baltimore for 34 years and former medical director of the Martha T. Berry Medical Care Facility in Mount Clemens where he also worked in the vocational rehabilitation center. Doctor Dudzinski was a Lt. Commander in the U.S. Navy during WWII. He was a member of the board of directors of Citizens State Savings Bank, a member of the Anchor Bay Knights of Columbia, New Baltimore Civic Club, and the VFW Post No. 7573.

Clarence E. Maguire, MD
Harper Woods

Clarence E. Maguire, MD, a Saratoga General Hospital Board member, died October 30. He was 80. Doctor Maguire received his medical degree from the University of Toronto in 1926. An orthopedic surgeon, he participated in numerous medical societies. He was nominated to the hospital board of trustees in 1976 and served a term as vice president. Doctor Maguire was affiliated with Evangelical Deaconess, Childrens and St. Johns hospitals of Detroit and also with Cottage Hospital of Grosse Point.

William S. McNary
Sun City, Arizona

William S. McNary, president of Michigan Blue Cross for 22 years, died November 3. Mr. McNary was 78. He was one of the original members of the Blue Cross Commission of the American Hospital Association (predecessor of the national Blue Cross Association).

Er Chang Ping, Sr., MD
Oshkosh, Wisconsin

Er Chang Ping Sr., MD, 79, Oshkosh, died October 24. Doctor Ping attended Ching Hua University in Peking, China, and received his medical degree from Yale University Medical School. He completed his residency in psychiatry at Howard, RI. He was a member of the American Psychiatric Association, and was a fellow of the American Geriatric Association. He was also a life member of the Rotary Club.

Carlisle F. Schroeder, MD
Grosse Ile

Carlisle F. Schroeder, MD, died October 21 after a long illness. Doctor Schroeder, 77, was a 1930 graduate of the University of Michigan Medical School. He studied at St. Hedwig's in Krankenhaus, Berlin, and was a Lt. Col. in WWII. He served with the Harper Hospital 17th General Unit in the U.S. Army. Doctor Schroeder was past president of the Detroit branch of the American Urologic Association and belonged to numerous other medical associations.

Allen R. Soble, MD
Southfield

Allen R. Soble, MD, a Southfield resident, died October 31 at the age of 48. Doctor Soble was the founder of Oakland Internists in Southfield, which

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School of Medicine
Department of Otolaryngology

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A Practical Approach

Wednesday, March 30, 1983

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Detroit, Michigan 48201
(313) 577-1180

specializes in oncology. He was a staff member of Sinai Hospital in Detroit, a fellow of the American College of Physicians, a clinical assistant professor at Wayne State University's School of Medicine, a member of Alpha Omega Alpha Medical Honors Society and Phi Lambda Kappa fraternity. Doctor Soble also was affiliated with Grace Hospital of Detroit and Highland Park General Hospital.

Raymond S. Van Bree, MD
Grand Rapids

Raymond S. Van Bree, MD, died August 30, at the age of 79. Doctor Van Bree, a 1929 University of Michigan graduate, was affiliated with St. Mary's Hospital, Grand Rapids for 52 years. His specialty was general surgery. He also served on the executive committee of St. Mary's Hospital and on the Board of Trustees of Wallin Congregational Church, and was a member of Phi Chi Fraternity.

MSMS does not favor mandatory medical staff coverage

The MSMS view of mandatory coverage for hospital staff members was summarized in a recent letter to a Detroit-area hospital administrator. Said MSMS in the letter:

While MSMS recognizes that physicians have a social obligation to carry professional liability insurance, evidenced by the fact that we capitalized our own professional liability insurance company, we do not believe that it must be mandatory. MSMS delegates at their 1981 annual meeting opposed compulsory insurance as a requisite for hospital privileges. MSMS believes that medical staffs themselves should make the decision whether to require the medical staff to have professional liability insurance.

The AMA Board of Directors emphasized recently: "The AMA is of the opinion that each hospital medical staff may determine for itself whether it will require coverage at the commonly prevailing level of policy limits as a condition for hospital staff privileges. The Board believes that if the organized medical staff makes this determination, the members of the medical staff should comply with the requirement."

We understand that Sinai Hospital has been discussing the issue with its medical staff. We would further encourage such discussion and participation with the medical staff to allow for appropriate input. We would hope that through such discussion, the medical staff and the Board of Trustees could come to a mutual agreement on this important matter.

If MSMS can be of help in bringing an agreement to fruition, we would be most happy to lend our assistance.

Sincerely,

James H. Tisdel, MD
President

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PRESIDENT'S PAGE

MSMS can lead efforts to end child abuse

James H. Tisdel, MD
MSMS President

The following is excerpted from a Dec. 1 special report to The MSMS Council from the MSMS Committee on Humanitarian Services. Doctor Tisdel is chairman of the committee.

Child abuse and neglect are issues of major social consequence in Michigan.

In 1982 there were 28,000 confirmed cases in our state, which experts believe represents only about 10 percent of the total problem. This awful situation can only be exacerbated by the high unemployment rate and the cessation of health care benefits for our unemployed. The magnitude of the social consequences of child abuse is connotated by studies showing 90 percent of inmates incarcerated for violent crimes are victims of child abuse.

There is a need for medical leadership on this heartbreaking issue. MSMS has taken a step toward assuming that leadership through the Council's creation of a new MSMS Committee on Child Abuse. MSMS Past President Brooker L. Masters, MD, Baldwin, has agreed to chair the committee. He also is a member of our Committee on Humanitarian Services.

The latter committee convened a multidisciplinary panel of experts this fall at MSMS headquarters, to ascertain the scope of the problem and propose solutions.

The MSMS committee earlier had studied the Michigan child abuse statutes and found them adequate. The problem, committee members decided, was the lack of an orchestrated effort to focus social resources on child abuse and neglect. In too many instances the medical community, protective services and the probate court's efforts have been disjointed, despite the fact that they all work toward the same end.

The most common problem cited by the panel of experts was the lack of physician participation in the reporting of child abuse and neglect. They uncovered several reasons for this lack of participation:

1. Physicians don't know the signs of child abuse/neglect.
2. Physicians do not understand the significance of not reporting cases.
3. Physicians have little confidence in the system.
4. Due in part to malpractice concerns, physicians will avoid court proceedings.
5. Court proceedings are too time-consuming for practicing physicians to participate.
6. Physicians anticipate they will be in an adversary relationship with other parties involved and do not feel they have a support group.
7. Physicians do not perceive their role to be that of a reporter of child abuse/neglect, and worry that reporting will destroy their physician/patient relationship.
8. Physicians generally have no reporting protocols.
9. Physicians will refer suspected cases elsewhere in the belief that another physician will do the reporting.
10. Physicians find it emotionally difficult to admit their patients are victims of child abuse/neglect.

In addition to defining the problems encountered by physicians confronted by child abuse, the new MSMS committee, with the aid of the expert panel, has developed several suggested avenues of action to increase physicians' involvement in the area.

There is a need and a demand for organized medicine to focus its resources on the issue of child abuse/neglect. Physicians cannot solve this complex social problem, but they are a key element in the solution.

The development of a communication link with the other agencies involved in child abuse and the probate court system is the single most important element in an effective child abuse program. If the physicians can communicate with the other agencies involved with child abuse cases, he/she will not have the sense of isolation and frustration currently experienced by many physicians.

Although there is an important role for MSMS to play, the effectiveness of the state's child abuse program depends on the involvement of physicians at the county level. This is because child abuse cases are handled by county departments of social services and probate courts.

There is a need for medical leadership on the child abuse issue which MSMS can fulfill at the state level. This need includes the aspects of communication with other organizations involved in this issue, medical advocacy on child abuse issues (particularly funding), the creation and dissemination of medical information relating to child abuse and the education of MSMS members on this issue.

As one conferee stated, "If we (organized medicine) are to assume a position of leadership, we have to hurry to catch up with our followers."

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- Caution patients about drinking alcohol, driving or operating hazardous machinery during therapy.

References: 1. Kales A *et al: J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **4.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **5.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Kales JD: *Pharmacol Physicians 4*:1-6, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*:25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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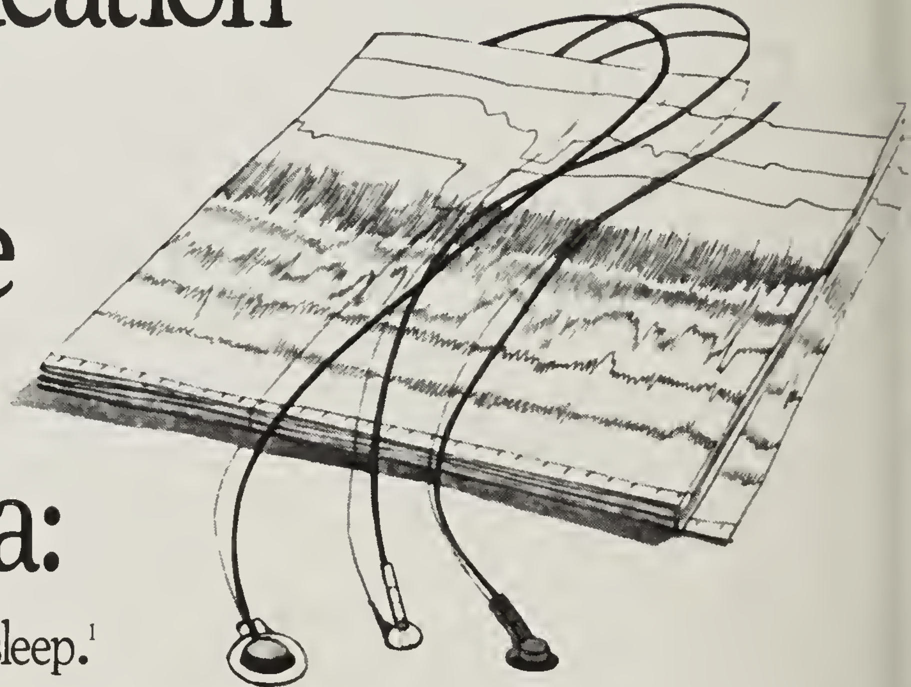

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Vol. 82, No. 4, January 20, 1983
Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

OUNCIL TO DISCUSS UBSCRIPTION O GTE TELENET

At this writing, MSMS councilors were scheduled to consider a trial subscription to the new GTE Telenet Medical Information Network. On the Council's Jan. 19 agenda were recommendations from an MSMS Task Force that the councilors test the electronic mail system for 90 days to determine its potential usefulness for MSMS members. Also on the agenda were Wayne County physician nominations to the board of the Physician Review Organization of Michigan, and MSMS Board of Managers elections.

SMS AWAITS TATE OF STATE, AX INCREASES

The MSMS Committee on State Legislation and Regulations will meet Feb. 2 to review effects upon health care of the governor's State of the State message and expected new state tax hikes. The intensity Michigan's new lawmakers and governor are giving to the state's fiscal dilemma has been emphasized by Senate Majority Leader William Faust's proposal for a 43 percent increase in the state income tax rate. He proposes an increase from 4.6 to 6.6 percent, effective Jan. 1, which would raise an estimated additional $1 billion for the current fiscal year. Governor Blanchard is expected to propose his own tax-and-cut proposal after seeing recommendations of his special financial crisis council sometime this week. Capitol rumors speculate that the governor's State of the State message Jan. 26 will deal exclusively with state finances and curative programs.

EY HOUSE OMMITTEE EMBERS NAMED

Michigan House Speaker Gary Owens has announced committee appointments for the House of Representatives. The Senate still is working on its appointments. House committees of special interest to MSMS are:

Appropriations: Democrats Jacobetti (Negaunee), chairman; R. Young (Taylor), Dodak (Saginaw), Emerson (Flint), Harrison (Pontiac), Hollister (Lansing), Hood (Detroit), Kilpatrick (Detroit), Mahalak (Romulus), Mathieu (Grand Rapids), O'Neill (Saginaw), and J. Young, Sr., (Detroit); and Republicans Ostling (Roscommon), Dillingham (Fowlerville), Dressel (Holland), Gilmer (Kalamazoo), Hayes (Midland) and Johnson (Royal Oak).

Insurance: Democrats McNeely (Detroit), chairman; Fitzpatrick (Battle Creek), Bartnik (Temperance), Bennett (Detroit), Brown (Kalamazoo), Dutko (Warren), Rocca (Sterling Heights), Sietsema (Grand Rapids), Weeks (Warren); Republicans Strand (Lapeer), Law (Plymouth), Middaugh (Bangor), Van Singel (Fremont), Wartner (Kalamazoo).

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Judiciary: Democrats P. Bullard (Ann Arbor), chairman; Smith (Detroit), Ciaramitaro (St. Clair Shores), Fitzpatrick (Battle Creek), Hertel (Detroit), Jondahl (East Lansing), Murphy (Detroit), Padden (Wyandotte), and Stabenow (Lansing); Republicans Nash (Dimondale), Kirksey (Livonia), Nye (Litchfield), Power (Traverse City), Strand (Lapeer), and Van Regenmorter (Jenison).

COMMITTEES, Cont'd.

Mental Health: Democrats Stabenow (Lansing), chairman; Stallworth (Detroit), Brown (Kalamazoo), DeBeaussaert (Washington), Hunter (Detroit), Parrott (Utica), J. Young, Jr. (Detroit); Republicans Sparks (Troy), DeLange (Grand Rapids), O'Connor (Ann Arbor), Strand (Lapeer), and Wartner (Kalamazoo).

Public Health: Democrats Evans (Mt. Clemens), chairman; Rocca (Sterling Heights), Barns (Westland), Docherty (Port Huron), Hertel (Detroit), Padden (Wyandotte), Stallworth (Detroit); Republicans Dunaskiss (Oxford), Brotherton (Farmington), Ehlers (Grand Rapids), Krause (Rockford) and O'Connor (Ann Arbor).

Taxation: Democrats Jondahl (East Lansing), chairman; Smith (Detroit), Bennane (Detroit), Brown (Kalamazoo), P. Bullard (Ann Arbor), Padden (Wyandotte), Scott (Flint), Stabenow (Lansing), Webb (Hazel Park), Weeks (Warren); Republicans Bryant (Grosse Pointe Farms), W. Bullard (Milford), Engler (Mt. Pleasant), Giese (Reed City), Hillegonds (Holland), Stacey (Berrien Springs), and Van Singel (Fremont).

Joint Rules: Democrats Griffin (Jackson), alternate chairman; Dutko (Warren), Smith (Detroit); Republicans Mueller (Linden) and Nash (Dimondale).

HCFA OFFICIALS MEET WITH MSMS

MSMS Bureau of Economics members met Jan. 19 with officials of the Health Care Financing Administration of Washington, DC. The meeting was called by HCFA to ascertain Michigan physicians' views on the Medicare program, and is one of several scheduled around the country by the federal office.

MSMS MEMBERS INVITED ON IRELAND TRIP

Sidney Friedlaender, MD, Southfield, president of the American Association for Clinical Immunology and Allergy, extends a special invitation to MSMS members to join an AACIA-sponsored CME meeting in Ireland. The event, which will award Category I credit, is scheduled April 16-24. Dublin and Killarney are the settings for the professional program, to which several of Ireland's foremost medical scientists have been invited. For further details, contact Richard Campau at MSMS headquarters.

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Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

MS COUNCIL
GHLIGHTS

The MSMS Council at its Jan. 19 meeting took a step toward the electronic modernization of MSMS communications by voting to subscribe on a trial basis to the GTE Telenet Medical Education network. The primary purpose of the trial subscription is to test the Med/Mail feature of the network. Each Council member will be provided necessary equipment to hook up to the system for one year, with evaluation scheduled in nine months. Should the system prove worthwhile, the Council then will recommend it for use by all MSMS members and will authorize MSMS to obtain a distributorship to enable members to tie into the system at an economical cost.

In other actions, the Council:
1) Heard a progress report from an ad hoc committee to study problems of the Michigan Board of Medicine. An MSMS position paper already delivered to Governor Blanchard recommends that the board should be staffed at a level sufficient to administer and carry out its investigative, administrative and compliance directives, and that a review should be made of the Department of Licensing and Regulation to determine the appropriate roles of the board and department in maintaining accountability for budget, personnel, investigations, complaint analysis and administrative law functions.

2) Elected seven board members to the Physicians Review Organization of Michigan. They are Burton J. Zack, MD, Novi, who fills both Wayne County and PSRO positions; Daniel R. Guyot, MD, Detroit, Robert M. O'Brien, MD, Detroit, Donald W. Visscher, MD, Dearborn, Wayne County representatives; William Weston, MD, Kalamazoo, at-large MD representative; Claire Keller, PhD, vice president for human relations for the Automobile Club of Michigan, public representative, and Floyd C. Stevens, Jr., DO, Auburn, Area IV PSRO representative.

3) Decided to invite representatives from the Michigan Radiology society to present their cost containment proposals at the next meeting of the Council's Health Care Delivery Committee.

4) Elected Justin L. Sleight, MD, Lansing, to serve a two-year MD-at-large position on the MSMS Board of Managers, and renamed Arthur A. Ulmer, MD, Detroit, to one-year, at-large term.

5) Wrote the Joint Commission on Accreditation of Hospitals to oppose language in the new JCAH accreditation manual which refers to "organized staff," rather than "medical staff." This is despite AMA approval of the "organized staff" term. MSMS is one of 300 organizations asked to comment on the new manual.

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GLORIA SMITH, PhD HEADS DEPARTMENT OF PUBLIC HEALTH

As this Medigram was prepared, MSMS had just learned of the appointment of Gloria Smith, RN, MPH, PhD, as director of the Michigan Department of Public Health. Doctor Smith, 48, dean o the University of Oklahoma School of Nursing, succeeds Bailus Walker, PhD, in the new Blanchard administration. She is a nursing graduate of Wayne State University and has a master's of public health degree from the University of Michigan. Doctor Smith, whose appointment is effective March 1 is one of three women named to lead departments of key importance to medicine. In addition to Doctor Smith, there are Sister Agnes M. Mansour, new head of the Michigan Department of Social Services, and Elizabeth P. Howe, director of the Department of Licensing and Regulations. Their appointments require Senate confirmation.

MSMS WORKING TO HELP ALLEVIATE INFANT DEATH RATE

The MSMS Committee on Maternal and Perinatal Health is studying the latest figures showing a rise in the infant death rate in Michigan, to determine the best MSMS action to help alleviate the situation. The committee, chaired by Gerald B. Holzman, MD. East Lansing, and Kenneth J. VanderKolk, MD, Grand Rapids, is examining statistics showing an infant mortality rate increase from 12.8 deaths per 1,000 live births in 1980 to 13.2 deaths per 1,000 live births in 1981, according to the Michigan Department of Public Health. The committee also is considering MDPH suggestions that Michigan physicians work to improve conditions by serving on community infant health promotion action committees as expert professional participants, developing a solid analysis of the pattern of infant deaths in their areas and, using the infant death study protocol, identifying "triggering events" for these deaths. MDs also, suggests Jeffrey R. Taylor, PhD, chief, MDPH Division of Maternal and Infant Health, might provide prenatal, delivery and pediatric services for the "new poor" in Michigan communities. The MDPH has set as its goal a reduction in infant mortality of 32 percent by 1990. The Department is offering $1.1 million in block grants to the 10 cities with the highest infant death rates. To date, the department believes the most likely reason for the climb in the infant death rate is the state's increasing numbers of poor.

PRIMARY SPONSOR PILOT PROGRAM ROLLS GROWING

Members of the MSMS Medicaid Liaison Committee are pleased with the progress of the Physicians Primary Sponsor Plan originated by the committee and now under the direction of the Michigan Department of Social Services. The pilot study is underway in Wayne County in an attempt to hold down Medicaid costs. As of Jan. 14, there were 1,002 Detroit-area physicians contracting to provide medical services to Medicaid patients through the PPSP. There were roughly 4,600 recipients enrolled in the program, according to Sally Hetrick, Wayne County administrator of the Department of Social Services program. MSMS is participating in the monitoring and evaluation projects crucial in evaluating the PPSP. Because the enrollment of recipients is being carefully forwarded, MSMS does not anticipate total enrollment of all Wayne County parties until late fall.

MDPAC ELECTS DOCTOR STONE NEW CHAIRMAN

Thomas E. Stone, MD, Muskegon urologist, is new chairman of the Michigan Doctors Political Action Committee. Doctor Stone was elected Jan. 19 to succeed Thomas C. Payne, MD, Lansing, who served as MDPAC chairman for four years. Doctor Payne earlier that day was elected assistant secretary of MSMS by the MSMS Council, and will continue to serve on the MDPAC board. Elected MDPAC secretary-treasurer to succeed Doctor Stone is Donald G. Blain, MD, Mt. Clemens.

In a related development, MSMS Council members learned Jan. 19 that former MDPAC Chairman Thomas R. Berglund, MD, is new secretary of the American Medical Political Action Committee. Doctor Berglund, who also is MSMS Council chairman, has served on the AMPAC board for three years.

HUNGRY, POOR TARGETS OF MSMS AID PROJECTS

MSMS Committee on Humanitarian Services members are mobilizing to develop the most effective ways to channel physicians' donations to the hungry and poor of the state. The committee, chaired by MSMS President James H. Tisdel, MD, Port Huron, has the go-ahead from the Council to raise funds and is investigating the best channels for those funds. The committee, which met cites the good success of other physician groups in funneling physicians' contributions to the needy. The Else Kolhede Foundation, a public foundation established by the Wayne County Medical Society, contributed $190,000 recently to Detroit-area emergency food providers. Ingham County Medical Society members recently donated $3,360 to local soup kitchens.

In other actions, committee members began investigating available standards to assist physicians in determining when to end medical care for the terminally ill, and began work to see that Michigan medical students are provided with instruction in the art, as well as the science, of medicine.

'BUCKLE UP--- YOUR DOCTOR CARES'

BUCKLE UP
Your Doctor Cares

You can promote seat belts, Doctor, by buying and wearing the attractive blue and white buttons shown at left. MSMS is making the buttons available to MSMS members at cost for distribution to patients, family and friends. MSMS is developing bumper stickers for public distribution as well, as part of a continuing effort to encourage seat belt usage. The buttons may be ordered below for $27/hundred (must be ordered in 100 lots).

_____ YES, I wish to support seat belt usage. Please send me ______ "Buckle up" buttons. (Please order in multiples of 100.)

My check for $_______ is enclosed ($27 x lots of 100)

Name ____

Address ____

MSMS FORMING SEAT BELT SPEAKERS BUREAU

MSMS Councilors Jan. 19 heard praise and thanks for efforts to date to ensure adult seat belt use in Michigan. Michigan Department of Public Health spokesman Maurice S. Reizen, MD, relayed MDPH Director Bailus Walker's request that Robert D. Burton, MD, be reappointed chairman of the Michigan Coalition for Safety Belt Use, and that MSMS provide a panel of physician experts to accompany state police troopers as they make public pleas for seat belt use. The Council approved both requests, and offered MSMS staff services to coordinate MDs' public speaking schedules. New legislation requiring safety belt use by drivers and front seat passengers is due to be introduced early in the 1983-84 session. During 1983, MSMS will continue to promote public awareness of the health benefits involved with seat belt use. Physicians interested in speaking before civic organizations are encouraged to call Ellen Vinocur Potash at MSMS headquarters.

MSMS OFFERS RIVER CRUISE THROUGH GERMANY

The year's next MSMS group travel package tour offers a 13-day Intrav adventure to the heart of Germany, including a six-day cruise of the Main River. Departure date is July 22, with return on Aug. 3. River travel is aboard the new M. S. Amicitia, exclusively chartered for the MSMS cruise. All major travel expenses are included in the price, as are three full meals each day aboard ship and breakfast and dinner in the cities of Mainz and Munich before and after the cruise. For further details, contact Donna Farougi at MSMS headquarters.

COMPONENT DUES VARY WIDELY

Local medical society dues in Michigan range from a high of $215 to a low of $20, with the average amount being $101. This data was compiled by MSMS in response to numerous requests. One county society (Luce) has a membership of eight doctors, and collects no dues. Thirty-three component societies pay $100 or more, while 25 pay less than $100. Size is not necessarily equated with amount of dues, as 17 component societies with less than 100 members have dues of $100 or more, while four components with over 100 members have 1983 dues of less than $100.

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Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

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GOVERNOR PROPOSES BUDGET CUTS IN HEALTH AREAS

Michigan physicians would be affected by state government budget cuts proposed by Governor Blanchard Jan. 27 in his State of the State message. The Department of Social Services, which administers Medicaid, would take general fund budget cuts of $60 million of the total $225 million in cuts proposed by the Governor. Proposed cuts of greatest interest to physicians include the following:

Social services: Medicaid services for podiatric and chiropractic care would be eliminated. Some DSS officials believe a large portion of the social services cuts could come in delayed payments to hospitals providing Medicaid services.

Public health: Family practice residencies providing a subsidy of $920 each for 326 family practice residents at 23 hospitals and clinics would be dropped, as well as poison control funding for centers at Grand Rapids and Detroit; clinical lab licensing positions and immunization consultation assistance positions to local health agencies positions.

Michigan's emergency medical services program would suffer severe budget cuts. The EMS program would retain responsiblity for licensure of ambulances and ambulance personnel, but would lose the areas of EMS planning, radio communication and disaster preparedness. Some physicians fear such cuts may imperil the state program, which has been touted as a national model.

Licensing and regulation: Eight licensing boards would be eliminated (nursing home administrators' board the only one medical), as well as the Medical Science Unit, which identifies incompetent medical practitioners, and the Drug Diversion Unit.

Mental health: Total cuts of $18 million are proposed, including elimination of psychiatric residency training programs for student residents at WSU and MSU.

RESTRUCTURING OF HEALTH CARE WASHINGTON TOPIC

Taxing employees for a portion of the health care benefits paid by their employers could increase federal revenues by as much as $3 billion, predicted participants in a policy forum Jan. 26-27 in Washington, DC. Deborah Zannoth, MSMS Bureau of Economics, said the tax on health care benefits was one of many new ideas presented at the forum on restructuring the health care financing system presented by the American Enterprise Institute. The AEI invited MSMS participation after meeting in Michigan with MSMS leaders and staff on past occasions to discuss the Physician Primary Sponsor Plan pilot project to contain Medicaid costs. Other new developments revealed at the Washington seminar included the news that Medicare reform will be big on legislative agenda as some observers believe the health care for the elderly system could go broke as early as 1988 if changes are not made.

DOCTOR VANDUYNE ELECTED PRESIDENT OF PROM BOARD

Frederick VanDuyne, MD, Flint family practitioner, is new president of the Physicians Review Organization of Michigan, organized by MSMS. Doctor VanDuyne was elected Jan. 26 at the first PROM meeting in East Lansing, which was attended by approximately 30 persons who are members of the new board and its advisory committee. Elected PROM vice president is Mary O. Anderson, MD, Leonidas; while Leroy Fahle, Detroit (Michigan Hospital Association representative to the board), was chosen secretary, and Robert Prophater, MD, Saginaw, was elected treasurer. PROM board members discussed structure of the organization and the needed committees. The next board meeting is March 9.

MSMS CONFERENCE FOR WOMEN PHYSICIANS MARCH 23

The second MSMS conference for Michigan women physicians is scheduled March 23 at the Michigan Inn in Southfield. A variety of provocative topics will be taken up at the day-long conference being planned by chairperson Miriam S. Daly, MD, Albion, and her committee of MSMS members. Keynote speaker will be Patricia Stuff, MD, speaker of the Wisconsin Medical Society House of Delegates. Luncheon speaker will be Rhoda Powsner, MD, LLB, Ann Arbor, who will discuss economic issues such as competition and reimbursement. Other topics will include sexual harassment, the medical marriage, organized medicine leadership, and professional choices.

U-M SEEKS PATIENTS FOR FIRST TRIAL OF PROSTACYCLIN

Patients with surgically unreconstructible arterial disease, who have rest pain or ulceration, now are eligible for treatment with intravenous prostacyclin at the University of Michigan Clinical Research Unit. This represents the first US-controlled trial of prostacyclin for this indication. Prostacyclin, a vasodilating and anti-platelet prostaglandin, has been used with moderate success in Europe. Physicians with potential patients are asked to contact Jack L. Cronenwett, MD, at the University of Michigan Department of Surgery, 313/763-5140 for details.

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Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

AN OPEN LETTER TO MSMS MEMBERS

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JUN 22 1983

The loss of health care benefits due to high unemployment has created a health care crisis in Michigan. As physicians, it is our responsibility to meet that crisis.

We all are aware of how the high unemployment rate has created a large pool of persons without health insurance. What you may not know is that many of these people are not eligible for social programs, such as Medicaid, because of the value of their personal property.

Because the recently unemployed are "cash poor," they avoid seeing physicians except in cases of emergency. As a result, many hospitals report an influx of sicker patients due to the lack of early treatment by physicians. Recent increases in Michigan's infant mortality rate also are being linked to high unemployment.

What can be done? The first line of response is with the primary care physician. We know our patients personally and can urge them to use health care services appropriately. Additionally, I urge you to consider providing free services or establishing a token fee or deferred payment system for your unemployed patients.

On a larger scale, there is an excellent plan of action being followed by southern Wayne County physicians and repeated elsewhere in the state. There, existing social agencies identify the "cash poor" unemployed persons who need health care services and refers them to physicians who will see them on a rotating basis for little or no payment, or on a deferred payment arrangement. The economic loss thus is borne more equally across the physician community. I urge county medical societies which have not already initiated this program to do so. MSMS will help provide basic information.

I recognize that many of you already have made significant contributions and I applaud you for your efforts.

However, the crisis continues, and I must ask you for further sacrifices. What I am asking is not as simple as writing a check. I am asking for a personal commitment from every physician, to shoulder part of the responsibility to meet the health care needs of the unemployed. It is a responsibility physicians cannot neglect. When I recall the oath we took, I know I can count on your support.

Sincerely,

James H. Tisdel, MD, MSMS President
Chairman, MSMS Committee on Humanitarian Services

HERE'S THE LINEUP OF KEY SENATE COMMITTEES

The Jan. 20 Medigram presented the rosters of the Michigan House of Representatives' committees which have an impact on physicians' practices. Here are the equivalent new committees on the Senate side:

Appropriations and retirement: Democrats DeSana (Wyandotte), chairman; Holmes (Detroit), Conroy (Flint), DiNello (East Detroit), Faxon (Southfield), Irwin (Sault Ste. Marie), Pollack (Ann Arbor), and Vaughn (Detroit); and Republicans Gast (St. Joseph), Welborn (Kalamazoo), Geake (Northville), DeMaso (Battle Creek) and Sederburg (East Lansing).
Commerce: Democrats Miller (Warren), chairman; McCollough (Dearborn), Barcia (Bay City); and Republicans Fessler (West Bloomfield) and Cruce (Troy).
Health and Social Services: Democrats McCollough (Dearborn), chairman; Vaughn (Detroit), and Conroy (Flint); and Republicans Binsfeld (Maple City), and A. Cropsey (DeWitt).
Judiciary: Democrats Brown (Highland Park), chairman; Serotkin (Mt. Clemens), and McCollough (Dearborn); and Republicans DeGrow (Pigeon) and Shinkle (Lambertville).

MSMS WORKING TO AVERT END OF RESIDENCIES

As this Medigram was written, MSMS was preparing to support the Michigan Psychiatric Society in its efforts to avert proposed elimination of psychiatric residency training programs in the state mental health programs and at WSU and MSU. The governor proposed eliminating the residency programs to reduce state deficits. MSMS supports the MPS view that such a move would have tragic effects and would create astronomical future costs to the state mental health system. Joseph Fischhoff, MD, MPS president, was to support this stand as MSMS Physician Legislative Network representative during an 8 AM hearing Feb. 10 of the House Mental Health Appropriations Subcommittee.

MSMS GAINING MORE MEMBERS

MSMS had 1,000 more dues-paying members as of Jan. 31 than it had at the same date in 1982. The increase includes 560 members who paid partial dues on the installment plan and 4,745 members who had paid full dues as of that date. In addition, Michigan recorded 600 more AMA members who had paid their dues by Jan. 31 than on the same date in 1982.

MEDIGRAM
Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Editor: Judith Marr

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Vol. 82, No. 7, February 10, 1983

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MICHIGAN MEDICINE

February 1983 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Volume 82, Number 8

Michigan says yes to Perinatal Care

Maternal Health Conference

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Whom to call at MSMS headquarters

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Annual Scientific Meeting	
Program	Sherry Fent
Meeting Facilities	Linda Munson
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Jail Health Project	Dick Campau
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Michigan Society of General Surgeons	Caroline Rich
Michigan Society of Respiratory Therapists	Caroline Rich
MSMS Committee Meeting Schedule	Katie Brewbaker
MSMS House of Delegates	
Agenda and Schedule	Dick Campau
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Public Health	Sherry Wellman
Specialty Societies	
Information	Nancy Wimmer
Committee of Specialty Society Presidents	William Madigan
Third Party Payors	John Richards

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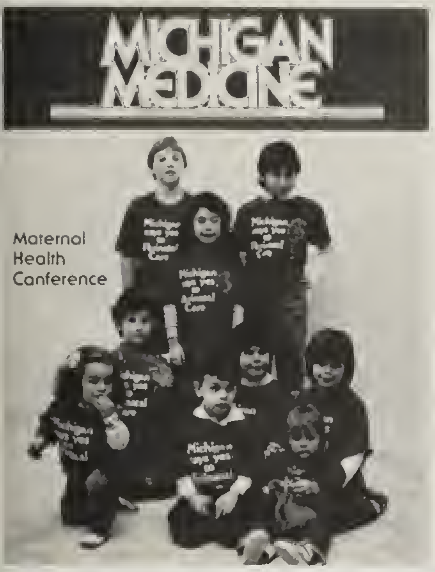

Happy, healthy kids are the goal of the 1983 Michigan Conference on Maternal and Perinatal Health, with its theme of "Michigan Says Yes to Perinatal Care." These kids, who are sporting theme T-shirts, happen to be the children of MSMS staff members. They are, from left, front row, Katie Madigan, David Paul Whitman and Laura Fent; second row, Cori Anthony, Rebecca Richards and Frances Fent; back row, Andrew Marr, Sarah Richards and Jodi Anthony. The T-shirts, by the way, are available on request from our photographer, **Mert Scholten,** MSMS staff.

MICHIGAN MEDICINE
February, 1983 Volume 82, Number 8

Special report

66 A distinguished faculty again is assembled to discuss a variety of current concerns at the 1983 Michigan Conference on Maternal and Perinatal Health. On pages 66-72 you will find conference objectives, chairman's remarks, speakers and their topics, program details and registration form. Once again, MSMS people are organizing the meeting.

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Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

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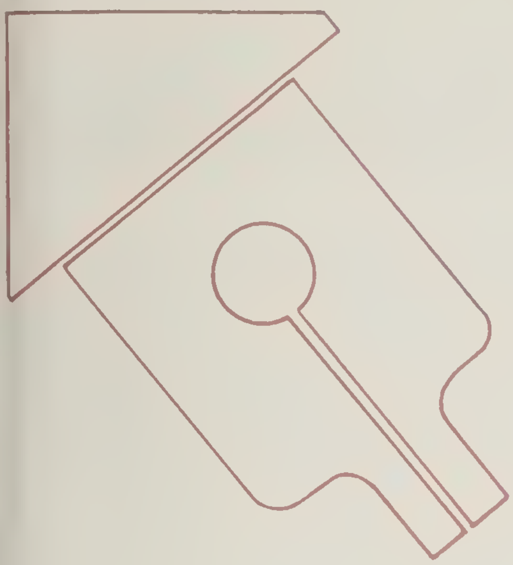
LETTERS



Kidney donations

Your organization can play a vital role in making the public aware of the need for cadaver kidneys for transplantation to those patients that have suffered kidney failure. Presently, in the State of Michigan we have 250 people awaiting a cadaveric kidney transplant, and we are asking you to help us meet this need.

The Organ Procurement Agency of Michigan is the central coordinating agency in the state for retrieval of cadaveric kidneys. We feel it is our responsibility not only to advise the Michigan community of the need for cadaver organs, but also to give them the option of giving the "gift of life."

In order to fulfill this responsibility, we are asking for the opportunity to present to any interested organizations a 15-minute slide presentation on the need for organ donation. Please feel free to contact us to schedule a presentation for a county society meeting, specialty group gathering or auxiliary function at your convenience. Our toll free number is 1-800-482-4881.

Sincerely,
Cynthia R. Giles, RN
Carolyn J. Emerson
Coordinators
Organ Procurement Agency
of Michigan
Ann Arbor

(See related article on page 90.)

Patients' welfare

I was very proud of you all this morning when your sponsored brief was aired against smoking and drinking. Our medical publicity usually reads out by many as self-serving, but this came across clearly and sincerely for the welfare of our patients. Best wishes,

R. C. Brown, MD
Owosso

Editor's note: The brief Doctor Brown refers to is a 60-second video tape prepared by the National Institute on Alcohol Abuse and Alcoholism and currently being broadcast over the Michigan State Medical Society name as a public service message over local Michigan television stations.

PROM members

I have just finished my December 9th, Volume 81, No. 55 copy of *Medigram* and it makes me wonder if I really want to pay my dues to the Michigan State Medical Society for this next year. After reading the lead article, I notice under "Council Highlights" that the Michigan State Medical Society Council approved and appointed the public representatives to the PSRO service areas.

I think we should probably take another look at this and review our positions that have taken place in the past 15 to 20 years regarding *physician* management. Specifically, it seems ironic PSRO — does that say physician? If it does, how can we tolerate public representatives on this committee?

I feel this is an important point to make and let us find out how far down the road to socialized medicine are we really going, and "being kicked in the ass" and pushed down the road by our good leaders in the Michigan State Medical Society Council. You can tell them for me that I for one think they are not doing a good job.

T. F. Richmond, MD
Cadillac

Editor's note: In a written response to Doctor Richmond, MSMS speaker Gerald H. Mandell, MD, and chairman of the task force coordinating PROM activities, clarifies the situation: The public members are two of 24 (the rest primarily physicians) on the new board of the MSMS Physician Review Organization of Michigan (PROM). They will not become involved in any peer review activities of PROM; those activities will be carried out only by physicians.

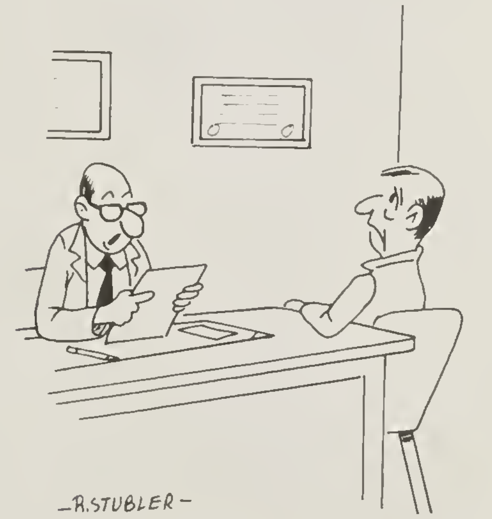
Medigram thanks

I am concluding my membership in the House of Representatives on December 31, 1982, and I have appreciated your kindness in maintaining me on your mailing list.

If your practice is to remove departing legislators from your mailing list, then this letter may serve as a checklist to enable you to do so. However, if your practice is to continue for a while to send to ex-legislators, I must say that your publication is so helpful that I would like to be retained on the list.

Again, I do thank you for helping to keep me informed while I was a member. We legislators put a high value on such sources of information.

William A. Ryan
State Representative
14th District
(now of Detroit)



"Depression, anxiety, loss of appetite, insomnia, irritability — hmm, income tax time again!"

Candidates for nutritional therapy...

10,000,000 alcoholics. Ethanol may produce many effects that together bring about nutritional deficiencies, so that alcoholism affects nutrition at many levels.[1]

25,500,000 geriatric patients. The older patient may have some disorder or socio-economic problem that can undermine good nutrition.[2]

23,500,000 surgical patients. Nutritional status can be compromised by the trauma of surgery; and some operations interfere with the ingestion, digestion and absorption of food.[3]

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The incalculable millions on calorie-reduced diets.

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highly acceptable to patients, has virtually no odor or aftertaste and is economical. And its "Rx only" status means more physician involvement, better patient compliance.

References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease, op. cit.*, p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease, op. cit.*, pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med 89* (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

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THE MULTIVITAMIN/MINERAL FORMULATION

1983 Maternal Health Conference boosts perinatal care

Conference dates and place: April 6-7, Grand Rapids

Medical teams working to assure good health of newborn and mother must study the light and dark sides of life.

That is evident in the planning for the coming 1983 Michigan Conference on Maternal and Perinatal Health. The conference, annually spearheaded by MSMS, is scheduled April 6-7 at the Grand Center and Grand Plaza Hotel of Grand Rapids.

From the joy of exercise for the healthy expectant mother to the tragedy of sexual disease transmitted to fetus and newborn, this conference will study the range of conditions seen and treated by the obstetrical/pediatric team.

"We have tried to respond to the requests of participants at earlier Maternal Health Conferences as well as offer talks on topics of key current interest," comments Gerald H. Holzman, MD, East Lansing obstetrician/gynecologist and chairman of the planning committee.

"In addition, we have sought to provide practical advice and information on subjects of daily perinatal care."

This year's conference, which annually draws 1,000 physicians, medical residents and students, nurses and other health care professionals, will offer a total of 13 category I credit hours and 11 hours of prescribed credit for family physicians.

The upbeat theme "Michigan Says Yes to Perinatal Care," is being printed on T-shirts which will be sold during the conference and are available to interested physicians through an accompanying order form on these pages.

Innovations of this year's conference include luncheon sessions with the "professors." These sessions, which require advance registration, are limited to 35 persons.

Key sessions deal with sexually transmitted diseases in pregnancy, work and recreation in pregnancy, responding to the public and low birth weight babies.

The convention facility and adjacent hotel are connected underground by tunnel, making the set-up for the two-day meeting convenient and pleasant for participants. Facilities are located in downtown Grand Rapids, close to shopping, restaurants, cultural centers and entertainment.

The complete program, registration form, lists of speakers, their professional titles and their subjects follow on these pages. Details and registration information are available from Katie Brewbaker at MSMS headquarters (517/337-1351).

Gerald H. Holzman, MD
Conference chairman

Objectives

The goal of the Michigan Conference on Maternal and Perinatal Health is to review, expound, and update our knowledge in all areas of perinatal health care. By attendance at this conference, the participant will gain knowledge regarding: (1) identification of sexually transmitted diseases and their early diagnosis, (2) therapy of sexually transmitted disease, (3) historical clues and clinical features suggesting early neonatal sepsis, (4) management of the septic infant, (5) the benefits of efforts to promote bonding in the early neonatal period, (6) methods of obtaining actual patient preferences and values and their use in decision making, (7) recommendation for pregnant women regarding sexuality, employment, and recreation, and (8) the challenges presented by the very low birth weight infant: obstetrical management, neonatal care, ethical decision making and legal status.

Luncheon discussion sessions will provide for information and exchange of topics of perinatal regionalized care, antepartum/intrapartum monitoring, midwifery, apnea monitoring, drugs in pregnancy and maternal transport.

The presentation in all areas will identify methods of implementation as well as theoretical considerations.

Michigan says yes to Perinatal Care

Yes, it's our gang again, to illustrate some of the problems we had in getting nine happy, healthy children to focus on a single objective — a good photo. We hope they will provide the impetus to convince MSMS members to register for the April 6-7 Michigan Conference on Maternal and Perinatal Health in Grand Rapids.

Participating organizations

The Michigan State Medical Society, and its Committee on Maternal and Perinatal Health, are proud to present the 22nd Annual Michigan Conference on Maternal and Perinatal Health. Participating organizations are:

- Michigan State Medical Society
- Michigan Academy of Family Physicians
- Michigan Chapter, American Academy of Pediatrics
- Michigan Department of Public Health
- Michigan Nurses Association
- Michigan Section, District V, American College of Obstetricians and Gynecologists
- Michigan Section, Nurses Association, American College of Obstetricians and Gynecologists
- Perinatal Association of Michigan

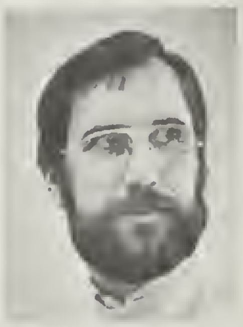
Here are speakers and their topics

Doctor Charles

Doctor Ziel

Doctor Lee

Ms. O'Rourke


Doctor Powell

Doctor Kretschmar

In the order of their presentations:

- **David Charles, MD,** professor and chairman, Department of Obstetrics and Gynecology, Marshall University School of Medicine, Huntington, WV

"Diagnosis and Management of Sexually Transmitted Diseases in Pregnancy"

Public awareness of the devastating effects of infections has increased considerably in the last few years.

The discussion will cover the use of preconceptional and prenatal screening for the presence of infectious agents. Useful methods available for diagnosis and the newest therapeutic regimens will be reviewed.

- **William L. Meadow, MD,** assistant professor, Neonatology and Infectious Diseases, Department of Pediatrics, University of Chicago

"Diagnosis and Management of the Septic Newborn"

The diagnosis of sepsis of the newborn can pose many difficulties. Prolonged rupture of the membranes, maternal fever, and abnormal laboratory findings often cloud the issue, especially in the neonate with respiratory difficulties. Therapeutic measures, including new antibiotics, will be discussed.

- **Luncheon Meetings:**

"Regionalized Perinatal Care"
Hermann A. Ziel, Jr., MD, chairman, MSMS Committee on Maternal and Perinatal Health, East Lansing.

"Antepartum Fetal Monitoring"
Chang Y. Lee, MD, director, Division Maternal/Fetal Medicine, Henry Ford Hospital, Detroit

"Certified Nurse Midwifery"
Thersa B. O'Rourke, RN, CMN, MPH, director of Nurse Midwifery Service, Sinai Hospital of Detroit
John W. Goldkrand, MD, director, Maternal/Fetal Medicine, Sinai Hospital, Detroit

"Apnea Monitoring"
Douglas P. Powell, MD, co-director, Neonatal Intensive Care Unit, Bronson Methodist Hospital, Kalamazoo

- **Robert M. Kretzschmar, MD,** professor and chairman, Department of Obstetrics and Gynecology, University of Missouri-Kansas City

"Obstetrics and Gynecology: Responding to Public Demands"

This presentation will address some of the ongoing public demands which represent both constraints and challenges to our specialty. These include changes brought about by the women's health movement, government regulations and cutbacks, and the increasingly litigious orientation of our society.

How can medicine in general and Ob-Gyn specifically be responsive to these demands in a positive way? This question will be discussed using a social interaction analysis of the health care system in relation to society.

- **Marshall H. Klaus, MD,** chairman, Department of Pediatrics, Michigan State University College of Human Medicine

"The Status of Bonding — 1983"

There are presently 20 randomized, controlled studies that have attempted to explore whether or not a sensitive period is present for the mother and father in the first days and weeks of life. Though a contact period for the adult does not fit with our presently accepted theories of human behavior, 16 out of 20 studies present evidence that this period may be important and alter a mother's behavior for as long as two months after delivery. In our complex society it is just possible that a small but significant number of parents might benefit by early and/or extended contact with their infant.

- **Marilyn L. Rothert, RN, PhD,** director, Lifelong Education, College of Nursing, research associate, Office of Medical Education, Research and Development, College of Human Medicine, Michigan State University

"Potential Role of Patient Values and Preferences in Clinical Decision Making"

Health care providers should be interested in their patient's preferences. However, options presented to patients sometimes are misunderstood. The discussion will focus upon strategies useful in eliciting actual patient values.

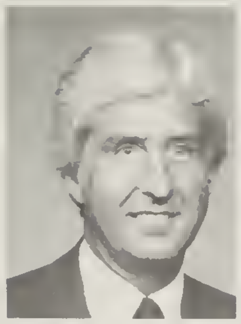
- **Robert M. Kretzschmar, MD**

"Sexuality and the Pregnant Patient"

This presentation will focus on issues related to sexuality in pregnancy. An attempt will be made to

Doctor Klaus

Doctor Rothert


Doctor Olthoff

Doctor Shangold

Doctor Rayburn

Ms. Brown

answer the following questions: How does pregnancy affect a woman's image of herself as a sexual being? Secondly, how does pregnancy alter the sexual relationship of a woman and her partner? And finally, under what conditions are certain types of sexual activity contraindicated during pregnancy and puerperium? A discussion of patient counseling in this area will be included.

- **Kenneth E. Olthoff,** general director, Worldwide Employee Benefits, Personnel Administration and Development Staff, General Motors Corporation

"Obstetric Disability: An Employer's Perspective"

In 1979, federal legislation was enacted which requires employers to treat disability resulting from pregnancy the same as all other illnesses or injuries for all employment-related purposes, including an employee's right to work and the payment of fringe benefits. The cost impact of the additional benefits made available to pregnant employees was significant.

This session will cover what one company did to establish cost-effective procedures to properly handle pregnancy-related disability benefit claims, what the claims experience has been under the new law, and what the role of the attending physician might be in evaluating a pregnant employee's ability or inability to work.

- **Mona M. Shangold, MD,** assistant professor of Obstetrics and Gynecology, director of the Sports Gynecology Center, New York Hospital/Cornell Medical Center, New York

"Advising Pregnant Women About Exercise"

Maternal exercise during pregnancy has become controversial because safe limits have not been determined. Long-term maternal benefits from training must be weighed against potential fetal risks from the metabolic, vascular, and thermal alterations which occur during each exercise session. It appears to be safe for women with normal pregnancies to continue exercising at the same level of perceived exertion they practiced prior to pregnancy.

- **Luncheon Meetings:**

"Intrapartum Fetal Monitoring"
Chang Y. Lee, MD, director, Maternal/Fetal Medicine, Henry Ford Hospital

"Drugs in Pregnancy"
William F. Rayburn, MD, director of obstetrics, Department of Obstetrics and Gynecology, University of Michigan Medical School, Ann Arbor

"Certified Nurse Midwifery"
Thersa B. O'Rourke, RN, CNM, MPH, director of Nurse Midwifery Service, Sinai Hospital of Detroit
John W. Goldkrand, MD, director, Maternal/Fetal Medicine, Sinai Hospital of Detroit

"The Role of the Referring Hospital in Perinatal Transport"
Karen M. Brown, RN, MS, regional perinatal coordinator, Saginaw General Hospital, Saginaw

- **Federico G. Mariona, MD,** director, Obstetrics and Maternal/Fetal Medicine, Hutzel Hospital/Wayne State University Perinatal Center

"The Very Low Birth Weight Fetus"

There is a direct relationship between neonatal weight and quality survival, so the obstetrician must be able to diagnose alterations of fetal growth during the gestational period. A proposed guidelines to evaluate these fetuses will be discussed.

- **Leonard L. Radecki, MD,** co-director, Gerber Neonatal Intensive Care Unit, Butterworth Hospital, Grand Rapids

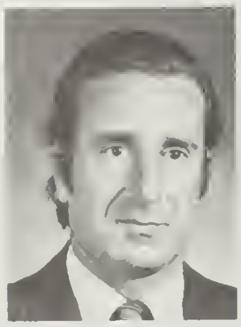
"The Very Low Birth Weight Neonate"

How small is too small? Survival of infants weighing more than 1,000 grams is routine. Even though survival between 750-1,000 grams is improving, morbidity is high. Survival under 750 grams is not a common event in most nurseries and today's question is how aggressive should we be with the very tiny infant. Statistics at various centers around the country will be compared with those from the state of Michigan.

- **Howard Brody, MD,** assistant professor, Family Practice and Philosophy, assistant coordinator, Medical Humanities Program, Michigan State University

"Ethical Issues in the Treatment of Low Birth Weight Babies"

Both the obstetrician and neonatologist face difficult ethical decisions of how aggressively to treat the immature fetus and premature neo-



Doctor Mariona

Doctor Radecki

Doctor Brody

nate. Increasingly these decisions must be made in an atmosphere of impending legal intrusion and widespread social disagreement over the moral values at stake. This session will trace some recent trends in the medical literature that cast the obstetrician and neonatologist in the role of child advocate. The impact of recent court decisions, attempts at the federal level to resolve the issue by legislation and administrative rulings, and the proposed ethical guidelines of the American Academy of Pediatrics will be addressed.

- **David J. Cooper, JD,** senior partner, Garan, Lucow, Miller, Seward, Cooper, and Becker, PC, Detroit

"Legal Pitfalls in the Treatment of Low Birth Weight Babies"

Contemporary technology allows the application of a variety of critical support systems to babies born too small, too early, or less than perfect. The salient aspects of plaintiffs' claims for errors of estimated fetal weight and failures to treat aggressively a fetus or neonate at pre-viable stages will be discussed. Attention will focus on the legal implications of regionalization, maternal transport, and special consents for treatment or refusal of treatment.

Michigan says yes to Perinatal Care

How could we say no to learning to provide the best care possible for moms and babies such as these? Promoting the Maternal Health Conference this time is Doctor Holzman's secretary, Marcia Weaver of Shaftsburg and her son, Jason.

Order Your Own 'Say Yes' T-shirt

MSMS members wishing to order "Michigan Says Yes to Perinatal Care" T-shirts may do so at $3.50 per shirt. They would make excellent gifts to maternity patients as well as to new mothers.

Available in red or blue with white lettering, the shirts come in small, medium, large and extra large sizes. Please specify color, size(s) and quantity desired. Checks should be made payable to MSMS.

Please send me the "Michigan Says Yes To Perinatal Care" T-shirt.

Color	Size	Quantity	Cost	Total

Enclosed is a check for $ ______ to cover the total cost of the shirt(s).

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Here is the Maternal Health Conference program and registration form

April 6-7, 1983
Grand Center, Grand Rapids

As an organization accredited for continuing medical education, the Michigan State Medical Society designates this continuing medical activity as meeting the criteria for 13 credit hours in Category I of the CME requirements of the Michigan Board of Medicine. The program has been reviewed and is accepted for 11 Prescribed credits by the American Academy of Family Physicians. Approval is pending with the Michigan Nurses Association for CEU Credit for nurses.

Wednesday morning, April 6

8:30 a.m. "Diagnosis of Sexually Transmitted Diseases in Pregnancy" — David Charles, MD, professor and chairman, Department of Ob-Gyn, Marshall University School of Medicine, Huntington, WV

9:05 a.m. "Diagnosis of the Septic Newborn" — William L. Meadow, MD, assistant professor, Neonatology and Infectious Diseases, Department of Pediatrics, University of Chicago

10:10 a.m. "Management of Sexually Transmitted Diseases in Pregnancy" — David Charles, MD

10:45 a.m. "Management of the Septic Newborn" — William L. Meadow, MD

Noon luncheon meetings

"Regionalized Perinatal Care" — Hermann A. Ziel, Jr., MD, chairman, MSMS Committee on Maternal and Perinatal Health, East Lansing

"Antepartum Fetal Monitoring" — Chang Y. Lee, MD, director, Division Maternal/Fetal Medicine, Henry Ford Hospital, Detroit

"Certified Nurse Midwifery" — Thersa B. O'Rourke, RN, CNM, MPH, director of Nurse Midwifery Service and John W. Goldkrand, MD, Director, Maternal/Fetal Medicine, Sinai Hospital of Detroit

"Apnea Monitoring" — Douglas P. Powell, MD, co-director, Neonatal Intensive Care Unit, Bronson Methodist Hospital, Kalamazoo

Wednesday afternoon, April 6

1:45 p.m. "Ob-Gyn: Responding to Public Demands" — Robert M. Kretzschmar, MD, professor and chairman, Department of Ob-Gyn, University of Missouri-Kansas City

2:30 p.m. "The Status of Bonding — 1983" — Marshall H. Klaus, MD, chairman, Department of Pediatrics, MSU College of Human Medicine, East Lansing

3:45 p.m. "Potential Role of Patient Values and Preferences in Clinical Decision Making" — Marilyn L. Rothert, RN, PhD, director, Lifelong Education, College of Nursing

Thursday morning, April 7

8:30 a.m. "Sexuality and the Pregnant Patient" — Robert M. Kretzschmar, MD

9:15 a.m. "Obstetric Disability: An Employer's Perspective" — Kenneth E. Olthoff, general director, Worldwide Employee Benefits, Personnel Administration and Development Staff, General Motors Corporation

10:30 a.m. "Advising Pregnant Women About Exercise" — Mona M. Shangold, MD, assistant professor of Ob-Gyn, director of Sports Gynecology Center, New York Hospital/Cornell Medical Center

Noon luncheon meetings

"Intrapartum Fetal Monitoring" — Chang Y. Lee, MD

"Drugs and Pregnancy" — William F. Rayburn, MD, director of obstetrics, Department of Ob-Gyn, U-M Medical School, Ann Arbor

"Certified Nurse Midwifery" — Thersa B. O'Rourke, RN, CNM, MPH, and John W. Goldkrand, MD

"The Role of the Referring Hospital in Perinatal Transport" — Karen M. Brown, RN, MS, regional perinatal coordinator, Saginaw General Hospital, Saginaw

1:45 p.m. "The Very Low Birth Weight Fetus" — Federico G. Mariona, MD, director, obstetrics and maternal/fetal medicine, Hutzel Hospital/WSU Perinatal Center, Detroit

2:15 p.m. "The Very Low Birth Weight Neonate" — Leonard L. Radecki, MD, co-director, Gerber Neonatal Intensive Care Unit, Butterworth Hospital, Grand Rapids

2:45 p.m. "Ethical Issues in the Treatment of Low Birth Weight Babies" — Howard Brody, MD, assistant professor, family practice and philosophy and assistant coordinator, Medical Humanities Program, MSU College of Human Medicine

3:15 p.m. "Legal Pitfalls in the Treatment of Low Birth Weight Babies" — David J. Cooper, JD, senior partner, Garan, Lucow, Miller, Seward, Cooper, and Becker, PC, Detroit

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Advance Registration

Please complete and mail to Michigan Conference on Maternal & Perinatal Health, Box 950, East Lansing 48823

Wednesday	**Physician**	**Nurse**	**Other**	**Student/ House Officer**
☐ Morning & Afternoon General Sessions	$25	$15	$15	No Charge
☐ Luncheon Meetings (limited to 35 people, indicate 1st & 2nd choices)				
___ Regionalization	$ 8	$ 8	$ 8	$ 8
___ Antepartum Monitoring	8	8	8	8
___ Midwifery	8	8	8	8
___ Apnea Monitoring	8	8	8	8
Wednesday total	$___	$___	$___	$___
Thursday				
☐ Morning & Afternoon General Sessions	$25	$15	$15	No Charge
☐ Luncheon Meetings (limited to 35 people, indicate 1st & 2nd choices)				
___ Intrapartum Monitoring	$ 8	$ 8	$ 8	$ 8
___ Drugs and Pregnancy	8	8	8	8
___ Midwifery (repeat)	8	8	8	8
___ Perinatal Transport	8	8	8	8
Thursday total	$___	$___	$___	$___

Name ________________________________

Address ________________________________

City ____________ Zip ____________ Phone ____________

Wednesday Total $ ________

Thursday Total ________

GRAND TOTAL $ ________

Checks payable to Michigan State Medical Society

Physicians help themselves by helping refugee families

By Charles R. Downs
East Lansing

Sometimes physicians gain more from doctor-patient relationships than the patients do. Such appears to be the case for Michigan doctors who have cared for Indochinese refugees since the influx of these immigrants in 1979-80-81.

Louis R. Zako, MD, a family physician in Dearborn Heights, thinks his experience has been typical. When first asked by a church to serve as the doctor for a Vietnamese refugee family, he hesitated. He was unfamiliar with Indochinese diseases, cultures and languages.

However, he accepted. And, by following bulletins from the Communicable Diseases Center about the kinds of diseases refugees were facing, he soon learned what to look for and how to manage the diseases he encountered.

For example, he became acutely aware of the need to consider the possibility of parasitic diseases — rarely a problem in his regular practice. Also, he looked for ringworm and other fungal diseases as well as tuberculosis and hepatitis.

Within a few months, his patients were free of the ailments they had brought with them. Later, when the mother of the family he was treating became pregnant, Doctor Zako provided obstetrical care in much the same fashion as he would have for any other patient. Eventually, he delivered the child in a hospital.

Although an interpreter was necessary during the initial visits, the father attended special English classes and soon was able to communicate directly with Doctor Zako.

Costs of the medical care initially were borne by Medicaid. Later, the father obtained work and Blue Cross/ Blue Shield coverage and began paying his own bills.

Recently, the family moved to Louisiana to escape Michigan winters. Doctor Zako misses them:

"They are bright and industrious people and it was a joy and privilege to work with them. I'm sure it has helped me more than it helped them.

"As doctors, we have charitable instincts and are hunting for worthwhile work. But frequently our attempts just end by making us mad at the political bureaucracy. This was different."

MSMS task force

In order to spread the responsibilities and opportunities for working with refugees, Doctor Zako, who then was chairing the MSMS Council, organized the Task Force on Indochinese Refugees, with Hector J. Inchaustegui, MD, Royal Oak, as chairperson. This action soon was followed by a series of articles in *Michigan Medicine* about the refugees, control of parasitic diseases, the medical problems they faced, their cultural backgrounds and other information. About 90 members of MSMS volunteered to help with the refugees.

Although no study has been made of the number of volunteer doctors who were actually asked to provide services, it appears that many of them — as well as some MSMS members who did not volunteer — provided care for the 2,000 refugees who have settled in Michigan.

Soon after their arrival, the refugees were given physical examinations and were found to have problems not typically seen in Michigan. A national study of 709 refugees showed that 61 percent had intestinal parasites and 55 percent had positive skin tests. Also, 14 percent had hepatitis B antigen, 12 percent had a positive VDRL and 37 percent had abnormally low hemoglobin levels.

Continued on page 75

Famous Pairs.

The Columbia space shuttle was a triumph of teamwork. And along with Young and Crippen went Anusol-HC Cream to treat prior anorectal conditions aggravated by "G-Force" stresses of exiting and reentering the earth's atmosphere.

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- ☐ Astringent, to protect against further tissue damage.
- ☐ Emollient, for easier bowel movements.

And, when pain is a special problem, Anusol® Ointment offers the benefits of the topical anesthetic pramoxine HCl.

TUCKS® Pre-Moistened Hemorrhoidal/Vaginal Pads

*The #1 hemorrhoidal** pad for added external relief and gentle cleansing.*

- ☐ Soothes, cools, comforts, and cleanses irritated anorectal areas.

Once pain and inflammation subside, for dual action recommend regular ANUSOL® and TUCKS.®

Please see opposite page for brief summary of prescribing information.

*Meeting of Am Soc Colon / Rectal Surgeons, May 1980
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Vaginal Uses — Comforting as an adjunct in postoperative care after episiotomies and other vaginal surgery or when relief from vaginal itching, burning or irritation is required.

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ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg, bismuth subgallate, 2.25% bismuth resorcin compound, 1.75%, benzyl benzoate, 1.2%, Peruvian balsam, 1.8%, zinc oxide, 11.0 mg; also contains the following inactive ingredients dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg, bismuth subgallate, 22 5 mg, bismuth resorcin compound, 17 5 mg, benzyl benzoate, 12.0 mg, Peruvian balsam, 18 0 mg, zinc oxide, 110.0 mg, also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water

Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling

The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in. external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery

Anusol-HC is especially indicated when inflammation is present After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations

Warnings: The safe use of topical steroids during pregnancy has not been fully established Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time

Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment

Prolonged or excessive use of corticosteroids might produce systemic effects

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued until the infection has been adequately controlled

Anusol-HC is not for ophthalmic use

Pregnancy: See "WARNINGS"

Pediatric Use: Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants

Dosage and Administration: Anusol-HC Suppositories — Adults Remove foil wrapper and insert suppository into the anus Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides Then maintain comfort with regular Anusol Suppositories

Anusol-HC Cream—Adults. After gentle bathing and drying of the anal area, remove the tube cap and apply to the exterior surface and gently rub in For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure Then squeeze the tube to deliver medication Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides Then maintain comfort with regular Anusol Ointment.

NOTE If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black

Anusol-HC Cream — one-ounce tube (N 0071-3090-13) with plastic applicator.

Store between 15° - 30° C (59° - 86° F).
1089G010

After these conditions were treated, the refugees began receiving health care according to the usual U.S. patterns, selecting their own physicians and acquiring health insurance as they acquired jobs.

"Doctors have looked at caring for the Indochinese as a challenge rather than as a burden," says Patricia Hepp, who directs refugee programs for Catholic Social Services of Lansing.

Ms. Hepp also points out that cultural perspectives sometimes stand in the way of quality health care, making it important for doctors to be aware of possible problem areas.

For example, nursing mothers in Vietnam typically eat a rather watery soup and it has been difficult sometimes to persuade them to accept a more nourishing diet. Also, when a hospitalized Vietnamese child died of Reye's syndrome, some members of the local Vietnamese community became somewhat leery of American medicine.

Language problem

Language, too, can be a problem, says Ms. Hepp. She recalls an instance when an Indochinese woman was considering sterilization. Ms. Hepp wanted to be quite sure that the woman understood exactly what was involved. After carefully explaining matters through an interpreter, she asked if the woman really understood. And the woman replied that she did: "What it means is that this thing inside the woman will be turned upside down."

One of the people who best understands Indochinese attitudes toward medicine is Thanh Phung, MD, a Detroit radiologist. Doctor Phung, a Vietnamese refugee himself, served as an x-ray technician in a Seattle hospital while studying for recertification.

He points out that both Western medicine and the more traditional Chinese herbal medicine were practiced in Vietnam. However, even refugees who formerly went to Western-trained doctors, find the American medical system different. One reason is specialization.

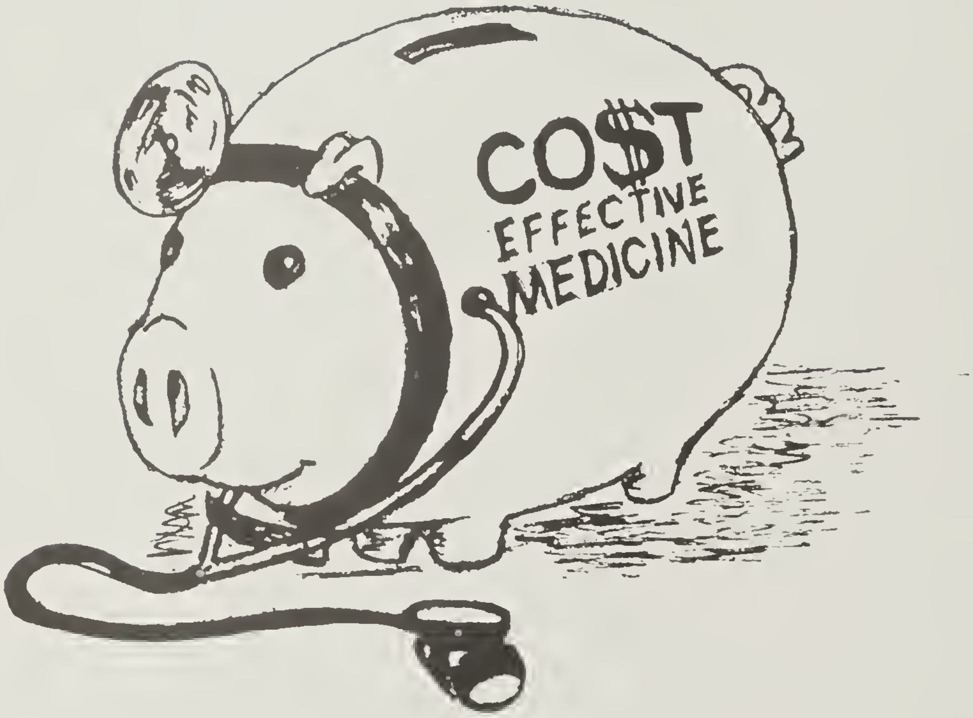
"They wonder why they have to see so many doctors," Doctor Phung explains.

Considering the emotional trauma and general uprooting that refugees have endured, one might expect to find a history of mental illness. However, no instances were reported by psychiatrists and mental health officials queried by this writer.

One reason may be the strong social support the Indochinese have received from their families, from other refugees and from their American sponsors.

However, according to Song-Song Nguyen, MD, a refugee who is now a psychiatrist at West Oakland Community Mental Health Clinic in Pontiac, the act of seeking any kind of mental health counseling runs counter to Indochinese culture. The people, she explains, are just too reserved and too private about their personal feelings to seek mental health aid, especially for neuroses.

Here is MSMS response to state report on MD reimbursement



Following is the MSMS analysis of the report of the Governor's Task Force on Physician Reimbursement. The MSMS Council did not support the entire report for the reasons presented below, despite the Council's support of some of the premises.

"... the Task Force touched on some very innovative concepts ... that deserve further exploration," said Louis R. Zako, MD, in a cover letter accompanying the MSMS analysis to the governor. Doctor Zako, who chaired an MSMS committee studying the report, expressed MSMS willingness to work on cost containment with the state government.

"A major problem with the task force discussion," said Doctor Zako, however, "was that it was predicated on the assumption that cost containment is the first priority of the health care delivery and reimbursement system. Consequently much of the work is not supportable ..."

Charge to the task force

The charge to the task force was so narrow that the report carries a bias that must be acknowledged before the work of the task force can be evaluated. The bias ingrained in the report is that cost containment is the first priority of the third party reimbursement system. The task force's findings become quite illogical when viewed from a perspective of patient advocacy, access to the physician of one's choice and the traditional role of the third party payer — to reimburse for those health care services that the consumer has been promised are available to him/her.

MSMS feels that the work of the Task Force has not yet been measured against any social priority except cost containment and that this measurement must be made before the work of the Task Force can be discussed as options for the health care reimbursement mechanism.

Assumption of the task force

The work of the Task Force, due to the narrow scope of its charge, seems to elevate some beliefs to the level of truth. MSMS feels that these beliefs need to be regarded from a proper perspective.

One such belief is that the capitation system of reimbursement is superior to all other mechanisms and should be promoted. MSMS believes that the evidence on capitated delivery systems regarding their ability to compete without governmental support is still being developed. The initial evidence shows that capitated delivery systems can provide quality health care at a reduced cost. While this delivery mechanism has a cost containment potential, there is no mention of the negative features of the capitation mechanism that make it acceptable to a small percentage of the population at the present time. MSMS believes that the 1980s will be a decade of experimentation in health care delivery and that a multi-option health care delivery system is advantageous. Therefore, all varieties of delivery mechanisms should be given an equal opportunity to compete without government support or hindrance.

Another belief given undue credence is that government regulation is a surrogate measure for properly acting market forces. The first priority of the government, at least for the task force's purposes, is cost containment. It is assumed that this is also the priority of a free market place. In fact, there is nothing to suggest that the consumers of care view cost containment as the highest priority. Consumers are more concerned with assuring that they have ready access to a full range of health care services. The assumption that government regulation is actually a surrogate measure for the will of the market place is contrary to logic. Government regulation to achieve cost containment is not to attain market place priorities, but rather to attain governmental priorities. Cost containment is a goal and it should not be dishonestly marked as the will of the market place.

The preferred provider option

A major thrust of the task force report, and the only original material

Continued on page 79

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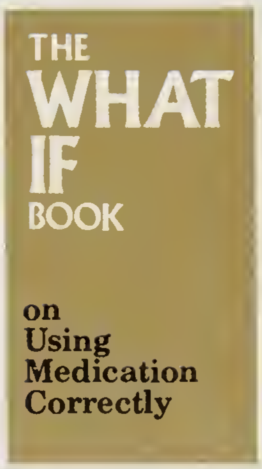
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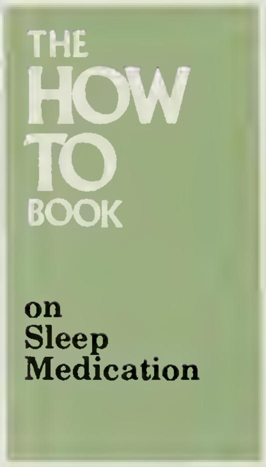
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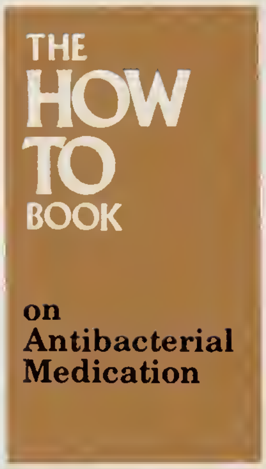
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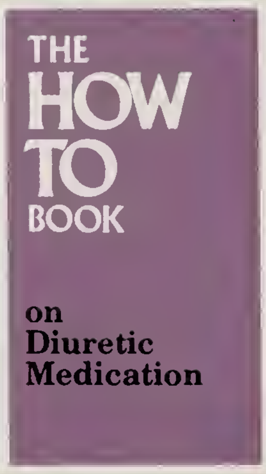
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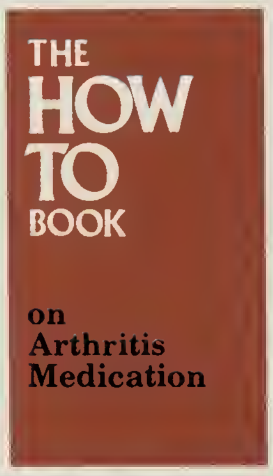
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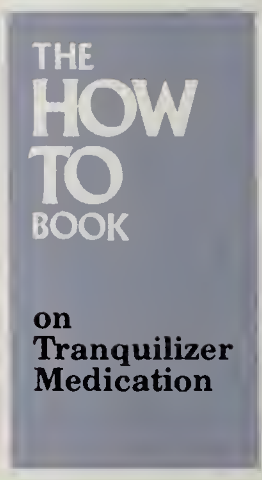
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in the report, is the promotion of the **preferred provider** concept. Despite the disruptive impact on other states, MSMS feels this concept has cost containment potential and deserves greater investigation. However, this concept is too amorphous in the task force report to permit serious consideration. For the purpose of future discussion, MSMS offers the following observations:

— There is an assumption that physician societies can set established standards of care so that non-physicians (third party reimbursers) can tell when a physician is providing poor quality service (too few services) or is abusing the system (too many services). In reality any such standards would be useful for only the grossest determinations. Any meaningful determination of over- or under-utilization of health care services would have to be done on an individual basis by physicians. This will be a time consuming and costly process whose cost must be born by the preferred **provider mechanism.**

— The sense of the task force report is that the **preferred provider** concept should be implemented immediately. Actually the **preferred provider** concept is still experimental and should be implemented on a pilot basis. Moreover, care must be taken so that the impact of the **preferred provider** experiment can be isolated from other experiments and social forces such as the Physician Primary Sponsor Plan, the developing HMO programs, prospective reimbursement for hospitals, DRG based hospital reimbursement and the increasing supply of physicians. It would be foolish to super-impose a **perferred provider** experiment on top of several other experimental programs.

— A non-judiciously implemented **preferred provider** program could leave the third party payers in the position of determining who could practice medicine in Michigan and what level of services could be provided. Clearly, it is not in the best interest of the public to have a financially motivated organization (a third party reimburser) making decisions about the allocation of health care services. Therefore, it is imperative that the third party payers not be given the economic leverage to force the physicians to place the role of patient-advocate second to a role of third party payer-advocate. A strength of the US health care delivery system is the physician's ability to secure the best possible care for his/her patient. This destruction of the patient-advocacy role would greatly change the philosophy of US medicine.

— The concept of "participating" and "non-participating" physicians is discussed along with the concept of payment and non-payment of physicians by third-party payers. These concepts are entwined in the task force report and must be clarified. MSMS supports the concept of non-payment of physicians for services which have been determined to be unnecessary by medical expertise. MSMS does not agree with the concept of non-payment of physicians in those cases where a third party payer makes a determination that the services were unnecessary. Third party payers are primarily financial mechanisms and must be expected to make determinations on a financial basis. Health care decisions should be based on medical rather than on economic expedience. Therefore, it is not appropriate to give third party reimbursers the economic leverage to determine the provision of health care services. The concept of non-payment is acceptable as a method of controlling the behavior of those who have consistently utilized health care resources in a medically unjustifiable manner. Non-payment is not an acceptable method of controlling the behavior of physicians whose actions are medically justifiable but whose utilization level is higher than the third party payer deems appropriate.

Physician distribution

MSMS feels that the assumption on which the physician distribution material is based is dated. The material seems to be based on the circa 1970 situation when the country still perceived a shortage of physicians and the prevailing attitudes about the benefits of medical specialization made it unlikely that rural areas would get an adequate number of physicians. Since that time, the nation has realized that it will have a physician surplus by 1990 and the need for primary care physicians has received increased emphasis. In Michigan alone the number of general practice/family practice residency positions increased 984 percent in the decade 1970-1980. An investigation of physician distribution patterns shows a gradual trend for physicians to locate in more remote areas of the state, indicating that the metropolitan areas are near saturation and market forces are working to distribute physicians. MSMS believes this trend is already evident and will develop rapidly over the next decade as the physician/population ratio increases by a factor of 30 percent. Market forces will not be able to create a perfect distribution of physicians, but the impact of market forces as a factor in physician distribution in the coming decades should not be overlooked.

MSMS objects to the assumption that reimbursement policies can influence graduate medical education programs so as to correct specialty imbalances. Thus far there is no agreement as to what constitutes an appropriate specialty distribution. The Graduate Medical Education National Advisory Committee has done some promising work in this area and the Michigan Council on Graduate Medical Education is studying the problem from a state perspective. As of yet, the methodologies to determine an appropriate specialty distribution and ascertain Michigan's national responsibility as a provider of graduate medical education are not established. Therefore, it is inappropriate to suggest that reimbursement mechanisms be used to influence graduate medical education programs.

The Task Force has identified some well-tried cost containment measures, such as co-pays and deductibles, and some innovative measures such as the preferred provider concept. MSMS looks forward to working with the state government on these experimental concepts toward the goal of a multi-option health care delivery system where consumer choice will cause competition to demand the greatest economy from the health care delivery system.

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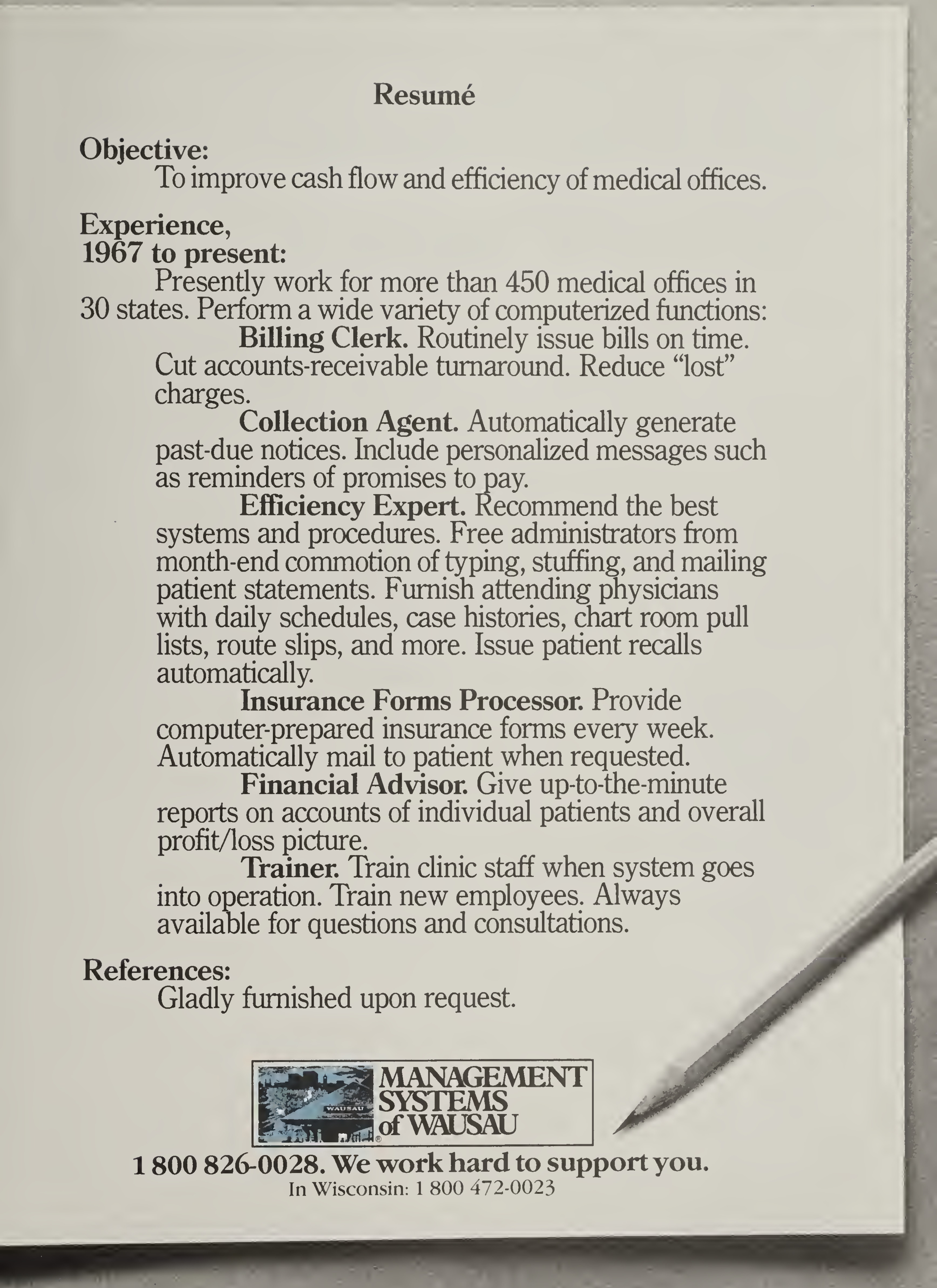

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The Greater Detroit Area Hospital Council's Ambulatory Care Pilot Study: Results and recommendations

By J. Si Nahra, PhD
Detroit

The manner in which ambulatory care is organized, delivered, and financed has become a major topic of debate in the health care community. Resolution of this debate will influence the type and amount of care provided as well as basic patient-provider, purchaser-provider, and physician-hospital relations. Despite the import of these issues, understanding of ambulatory care is rudimentary and based on limited information.

In order to begin to fill this information void, the Greater Detroit Area Hospital Council (GDAHC) undertook a pilot study of 12 hospital satellite clinics located in southeast Michigan. A description of the study approach appeared in the January, 1982 issue of *Michigan Medicine*.

This article summarizes the results of the pilot effort and suggests next steps that the pilot study experience indicates are both warranted and feasible. Those wishing to obtain the full report should address their requests to Mrs. Patricia Horton, GDAHC, 1900 Book Building, Detroit 48226. The price of the report is $5 per copy.

GDAHC's ambulatory care pilot study addressed four basic questions:

- What are the major forces shaping the ambulatory care delivery system?
- What is the most meaningful way of discussing the ambulatory care delivery system?
- What characterizes hospital-based ambulatory care satellite clinics?
- What next steps in furthering the discussion and understanding of ambulatory care appear warranted and feasible?

Doctor Nahra is director of research for the Greater Detroit Area Hospital Council.

Illustration 1

Possible Guidelines for Categorizing Ambulatory Care Organizations According to the Type of Care Available

Type of Specialty	Number of Specialties			
	Single		Multiple	
	# of Services		# of Services	
	Less than 5	5 or more	Less than 5	5 or more
Non-Primary				
Primary				
Primary & Non-Primary	N.A.	N.A.		

N.A. — Not Applicable: These organizations, by definition, have more than one specialty.

Major forces shaping ambulatory care

When viewed over time, the most striking feature of the ambulatory care delivery system is its increasing organization. Actions by patients, physicians, educational institutions, third-party intermediaries, public policies expressed by state and federal governments, private foundations, and the Joint Commission on Accreditation of Hospitals all have encouraged the development of more organized delivery settings for ambulatory health care and the involvement of acute care hospitals in its delivery.

Generally speaking, five main forces can be identified that have encouraged the organized delivery of ambulatory health services. While started at different times and for different reasons, these forces persist today and create what can be best termed an "organizational imperative" that profoundly influences the ambulatory care delivery system. The five forces are:

1. Service to the poor
2. Medical education and specialization
3. Union and industrial service to employees
4. Group practice movement
5. Health system integration

Each will be considered in turn.

Service to the poor

Since the 1800s, governmental entities and hospitals have served as organizers and financiers of physician services for the poor. Direct governmental involvement continues via services provided by local health departments. Outpatient clinics have become a permanent department of most inner-city hospitals where they are major providers of primary care to the indigent. The federal government also has played a significant role in encouraging the development of or-

Continued on page 84

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.. Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg . Postpuberal cryptorchism, 30 mg **REFERENCE:** R B. Greenblatt, M.D.; R. Witherington, M.D.; I. B Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg in bottles of 60, 250. Rx only.

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ganized ambulatory care in service to the poor via programs providing capital and operating monies as well as physicians.

Medical education and specialization

With the development of the intern and residency training program approach to medical education in the early part of the 20th century, the practice of organizing ambulatory care clinics as teaching arenas became widely adopted. This use of ambulatory care has been encouraged by the establishment of specialty hospitals, boards, and approaches to medical education. Almost all of the hospitals in southeast Michigan with major commitments in ambulatory care started their programs for this reason.

Union and industrial service to employees

Scattered throughout America's industrial history are numerous efforts by either companies or cooperatives of similar beneficiaries to gain access to physician care by establishing organized sites of ambulatory care. These efforts have resulted in numerous organized group practices of physicians coordinated with inpatient programs for the benefit of employees and their families. In the Detroit metropolitan area, the current Health Alliance Plan was started in the late 1950s as the Community Health Association.

Group practice movement

Two phases of group practice development appear to have taken place. The first phase, starting in the 1930s, coincided with the development of more advanced and complex medical care techniques as well as the formation of the American medical specialty boards. This phase was characterized by large multi-specialty groups with a significant degree of internal patient referral. The second phase was influenced more by social, economic, and political considerations. State statutes, first passed in the 1950s, permitted physicians to form professional corporations. PCs initially were opposed by the federal government, by organized medicine, and by the general public. By the mid 1960s, however, opposition by both organized medicine and by the federal government turned to support and assistance. Several actions by the federal government helped establish group practices by providing favorable incentives regarding loans, mortgage insurance, and employee benefit provisions. Nationally, group physicians now compose close to one-third of all non-federal physicians.

Health system integration

During the 1970s the most recent phase in the organization of ambulatory health care has occurred: integration of the health care delivery system. Health care system integration has occurred in two areas: service delivery and reimbursement. The driving force behind integration efforts appears to be an attempt to influence and control overall utilization of health care services. Hospitals, physicians, and third-party payers all have played active roles in health system integration.

Throughout the last decade many hospitals across the United States and in southeast Michigan began to plan and provide ambulatory care programs by design. Hospitals also worked to alter third-party reimbursement and otherwise extend external funds to the support of the ambulatory care programs during the 1970s. The establishment of 29 satellite ambulatory care centers in southeast Michigan is the most direct evidence of these efforts.

Increasing emphasis during the 1970s also has been directed at integrating health care service reimbursement. The two leading actors in this approach to integration are physicians and third-party payers. Various models of service delivery have been established and others are under development in response to reimbursement approaches to health system integration.

Physician groups have developed and sponsored two basic HMO organizational models — independent practice associations and closed panel group practices. Throughout the United States today there are just over 100 qualified HMOs in operation, seven of which are in southeast Michigan.

Michigan Blue Cross and Blue Shield initiated efforts in Michigan to organize the delivery of ambulatory health care services through the acquisition of group practice HMOs and the development of the Primary Care Network. Medicaid's Physician Primary Sponsor Plan is the most recent example of health system integration encouraged by a third-party payer in Michigan.

Continued on page 86

An added complication... in the treatment of bacterial bronchitis*

Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin Resistant Haemophilus influenzae
H. influenzae
S pneumoniae

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

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Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation. When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by C *difficile* Other causes of colitis should be ruled out

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug.

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur. This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly).

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0 18, 0.20, 0 21, and 0 16 mcg/ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor® (cefaclor, Lilly) is administered to a nursing woman

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions. Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis/arthralgia and, frequently, fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

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*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either S *pneumoniae* or H *influenzae* [8]

Note: Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

References

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How to discuss ambulatory care?

This pilot study assumes that before further discussions can occur, a commonly accepted perception of ambulatory care must be developed. The various parties involved in discussion of ambulatory care must all be comparing "apples with apples." In deciding on a meaningful way to discuss ambulatory care, the purpose of these discussions must be understood and a common approach agreed upon.

Purpose

Whether one discusses ambulatory care in terms of how it's paid for, organized, or delivered, there is the need to understand the type of care available at an ambulatory care site. If comparable descriptions of care available at sites "A" and "B" are not used, further discussions of any topic are greatly complicated. In seeking to describe the type of care available at various sites, the recommended approach should be easy to understand (to the extent possible familiar concepts and terms should be used), flexible and capable of refinement.

The definitional approach GDAHC recommends for use meets these criteria. The approach categorizes ambulatory care sites according to the type of care available using the following characteristics: the number of specialties present; the type of specialties represented; and the array of services offered.

Approach

GDAHC's definitional approach is similiar to the American Medical Association's (AMA) classification of group practices by physician specialty. This correspondence shows promise for developing a definitional scheme applicable to overall physician-related ambulatory care. GDAHC's definition of ambulatory care organizations represents a refinement to the AMA's approach in that it considers more than the physician's specialty. Sites are defined according to the type of service available using specialty information, but also considering the array of services offered by an organization. Integrating these two approaches produces a set of definitional characteristics and categories with the potential for broad applicability. A set of guidelines for relating definitional characteristics and categories is suggested in the following illustration.

The illustration uses the following characteristics and guidelines:

— Number of specialties (Organizations are differentiated according to those with a single specialty or multiple specialties).

— Number of services (The pilot study cut-off of fewer than five/five or more services is suggested).

— Type of specialty (Physician specialties are grouped broadly into primary and non-primary classifications).

When combined, these characteristics produce ten possible categories for physician-related ambulatory care organizations. The exact number of categories will depend on how the characteristics are structured. For example, sub-dividing physician specialties to identify surgical specialties creates additional categories. Subsequent analyses should attempt to include a representative sampling from each of the major organizational categories identified. Use of key modifiers such as ownership, size of medical staff, and length of operation is also recommended.

What characterizes hospital based ambulatory care satellite clinics?

The major data gathering component of the pilot study consisted of case studies of decentralized ambulatory care units established by seven hospitals in southeastern Michigan since 1975. Two methods of data collection were employed.

- Personal interviews in which study team members asked questions concerning the development and operational experience of each site as well as the opinions of participants regarding ambulatory care;
- Survey instruments which collected factual data on each site's ownership, operation, staffing, finance, physical layout, and use.

The pilot study experience served as a pretest of these data tools for further analyses. It showed that these forms can be modified and used as part of a follow-up study encompassing a broader range of ambulatory care organizations.

Based upon the type of care available, the 12 sites were divided into two groups of six each. The first group, referred to as general/family practice sites, contained only primary care specialties and offered few services beyond routine physician care. Multispecialty sites formed the second group; they were characterized by affording access to both primary and non-primary physician specialties as well as a broader range of services.

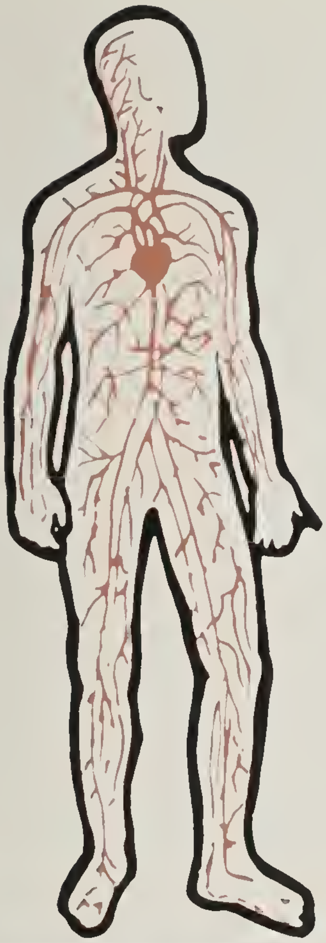
Key observations from the case study data analysis include:

1. In all but one case, multispecialty sites were owned by the hospital; had separate administrative staffing; granted their physicians admitting privileges; and employed more personnel for specialized services.

2. Family practice sites were frequently leased; used the medical director as part-time administrator; did not uniformly extend admitting privileges; and, employed fewer individuals.

3. Multispecialty sites were larger in terms of overall square foot-

Continued on page 88



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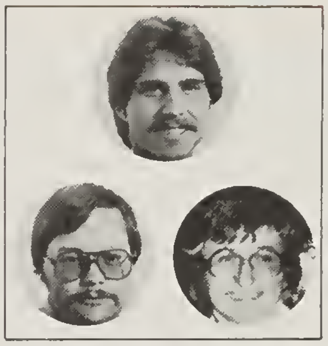

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AMBULATORY CARE STUDY/
Continued

age but both groups allocated their physical space to various functions in equivalent proportions.

4. Fees for initial physician visits, follow-up visits, and emergency room visits were comparable at all sites.

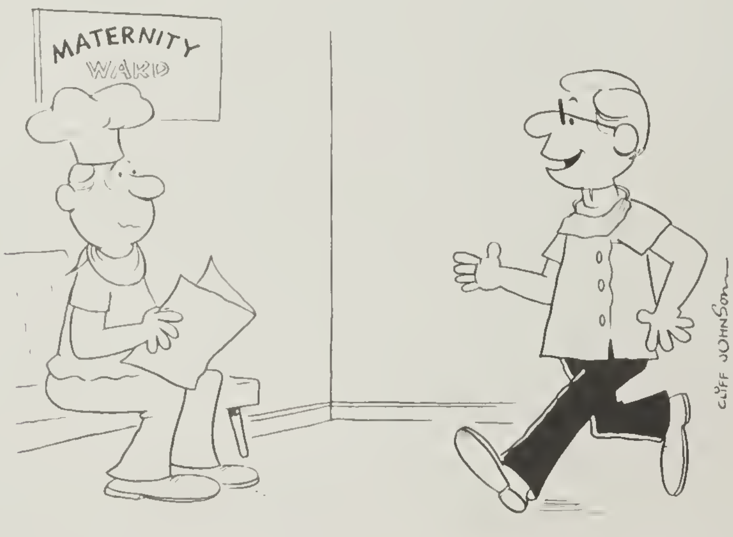
What next?

Pilot studies are exploratory and developmental in nature. Their value is judged not only by the specific findings derived from the pilot effort, but also by the guidance the findings provide for more in-depth analyses. The GDAHC ambulatory care pilot study recognized this when it set as a goal ". . . establishing a foundation of information upon which subsequent ambulatory care data development, research, and planning can build."

The foundation provided by the pilot study is a strong one. Each of the study's objectives was achieved. The knowledge gained from this effort has served to underscore the import of ambulatory care organization and demonstrate that this aspect of the health care delivery system is amenable to analysis.

A follow-up study should be more comprehensive than this pilot effort. Focusing on one portion of ambulatory care (i.e., hospital satellite clinics) is acceptable in a pilot study but is too limited for an overall analysis of ambulatory care. The recommended definition of ambulatory care organizations presented in this report suggest physician-related ambulatory care as a relevant universe for subsequent study. Physician-related ambulatory care refers to the delivery by physicians of non-institutional personal health services in hospital and non-hospital based organizations. In analyzing ambulatory care, data collection should be carefully limited to information that is related to a stated purpose, comparable across sites and not burdensome to collect.

Ultimately, the feasibility and success of any follow-up study will be contingent upon the involvement and commitment of the various participants in ambulatory care. All follow-up study activity should involve a broad spectrum of participants in ambulatory care delivery, reimbursement, and planning. Formal mechanisms for the development, execution, oversight, and review of follow-up study efforts should be established. GDAHC intends to pursue such broad-base follow-up studies. These efforts will be communicated in subsequent articles.



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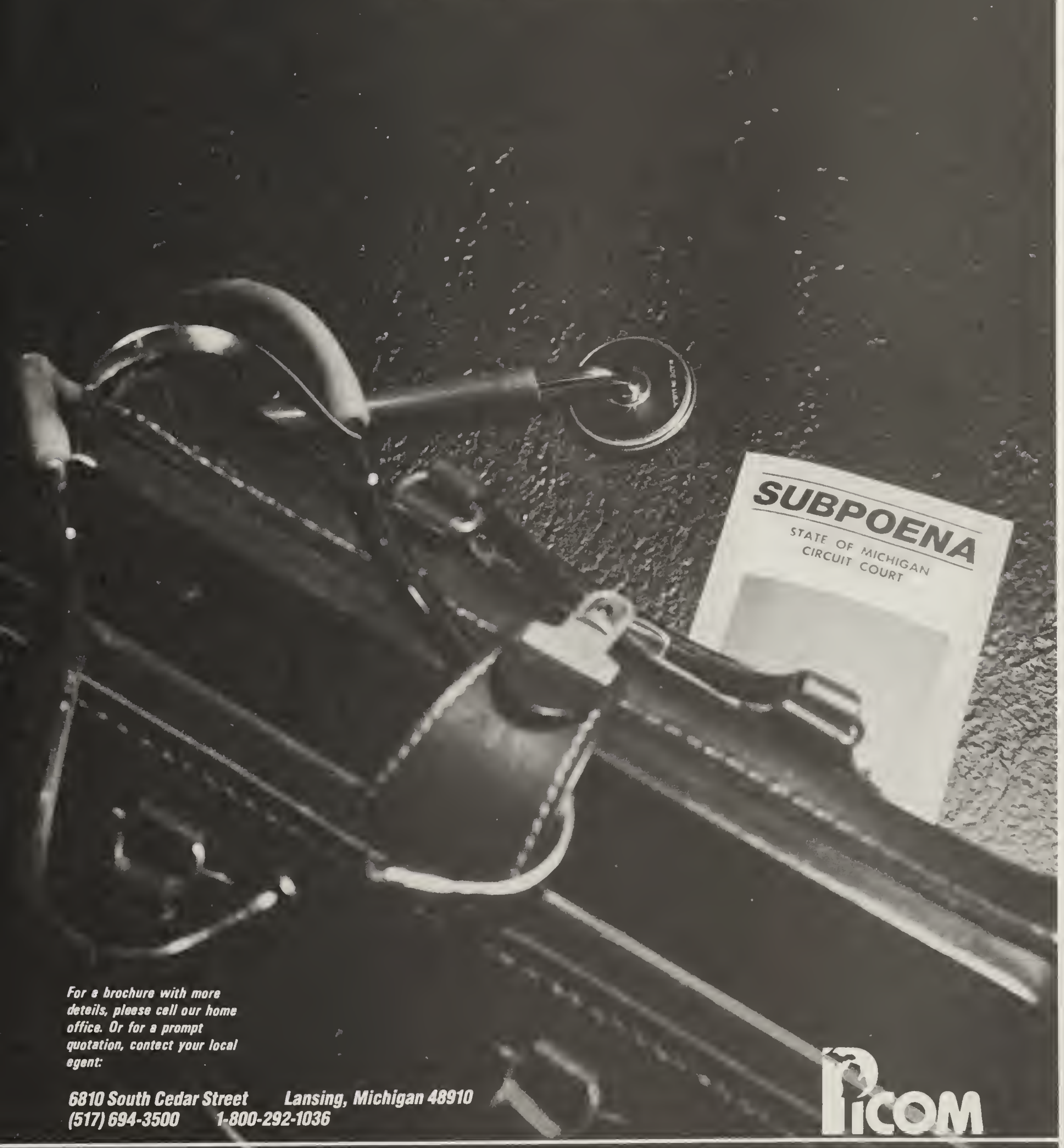

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Michigan's crisis in kidney transplantation

By Sanford B. Izenson, MPH
Maurice S. Reizen, MD, MSPH
Lansing

"Only about one percent of eligible kidneys for transplant are being donated in Michigan. Too many are being buried."

Those were the comments of State Bureau of Personal Health Services Director Maurice S. Reizen, MD, as he submitted this article. Doctor Reizen was concerned with the large discrepancy between the number of kidneys needed and the few being donated.

"We need to sensitize the physicians of the state, particularly those in the emergency rooms, to the need for kidneys," he continued. That is what the following article attempts to do. Doctor Reizen, his co-author Mr. Izenson and *Michigan Medicine* hope this article will initiate a groundswell of greater support and participation in the kidney donation program among Michigan physicians.

Michigan is facing a quiet crisis. The supply of cadaver kidneys available for transplantation to Michigan's dialysis patients has been falling behind the need for years. And the situation may get worse.

In two years, Michigan has gone from relative self-sufficiency, regarding supply of cadaver kidneys, to the point that about one-third of its kidneys come from outside the state. In addition, over the past three years the number of persons waiting for a cadaver kidney has climbed from a relatively stable 100 to about 250, with no signs of leveling off.

Michigan was an early leader in the field of kidney transplantation, thanks to the establishment in 1972 of the Transplantation Society of Michigan. The TSM is a private, non-profit organization promoting and coordinating the use of kidney transplantation. An operating grant from the State Health Department Kidney Program supported the new organization for its first three years of existence. It then became self-supporting through reimbursed fees for service by the new federal kidney program.

Michigan's growing success and competency in transplantation is reflected in the program statistics.

The increase in the waiting list is apparently due to the increase of end-stage renal disease (ESRD) patients, which has continued unabated at least since the Federal Kidney Program came into being. There is too short a time since establishment of the federal program to show a direct relationship, between it and the increase in the waiting list. There also are other significant factors related to age, sex, race and type of facility as well which affect the size of the waiting list.

The FDA's approval of the new anti-rejection drug cyclosporin II, expected in a few months, will produce a much more significant impact on kidney and other cadaver organ transplantation. Experimental results have shown that cyclosporin II has improved cadaver organ survival rates dramatically from about 50 percent to about 80 to 90 percent within one year. This will revolutionize the field, probably minimize the use of live kidney donors as well as sharply increase the attractiveness and use of cadaver kidneys. This scientific advance, however, may well bring with it an unprecedented demand for cadaver kidneys. This could act especially harshly on Michigan patients, due to our heavy use of out-of-state kidneys mentioned earlier. Kidneys are made available to outstate or non-network cadaver kidney coordinating organizations only after all member programs of the source organization have declined to accept the kidney. Thus our state would likely be forced to rely only upon our own kidney resources for future cadaver organs.

The requirements for cadaver kidney donorship begin with willing next-of-kin. The age range is between five and 35, and there should be normal kidney function and structure, no active infections or cancers that might affect the organ, no general circulatory disorders or high blood pressure, and the donor should be on a respirator and declared brain dead with the surgeon, technician and perfusion equipment present and ready for action as soon as brain death is declared. For this last criterion to be

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Mr. Izenson is Renal Consultant, Division of Chronic Disease Control, and Doctor Reizen is Deputy Director for Health Promotion and Disease Prevention, Michigan Department of Public Health.

NOTE: The Transplantation Society of Michigan (TSM), with its subsidiary organization, the Organ Procurement Agency of Michigan (OPAM), offers a wide range of services supporting kidney transplantation, including 24-hour consultation and coordination; direct payment source for all costs and professional fees associated with kidney harvesting and transplantation; surgeons always on call to perform nephrectomies when an experienced surgeon is otherwise unavailable; a kidney procurement van with preservation equipment always available; a central serum repository for all Michigan residents awaiting a cadaver kidney, in order to permit crossmatching with a prospective donor through one of four rotating laboratories; inservice hospital education on kidney harvesting, with the help of TSM staff; and a weekly listing of all Michigan dialysis patients awaiting a cadaver kidney, by name, age, race, institution, blood type, medical status re transplantation, previous transplants received, percent cytological reactions, HLA antigens, mismatched antigens, and antibody specificity. The TSM state-wide toll-free number is 1-800-382-4881, and their address is 3364 Washtenaw Ave., Ann Arbor, 48104.

Table: Kidney Donation Statistics, by Year

	Harvested	Received Out-of-State	Sent Out-of-State	Transplanted	Number of Patients on Waiting List at Year's End
Calendar year 1982 totals (thru Dec. 29)	156	71	3	196	257
Calendar year 1981 totals	176	63	5	191	218
Calendar year 1980 totals	166	22	6	156	168
Calendar year 1979 totals	188	11	19	146	102
Calendar year 1978 totals	152	7	11	118	104

met, kidney harvesting organizations usually focus their efforts on hospitals treating many trauma victims with head injuries, who can be identified in their emergency rooms and intensive care units early enough to allow the necessary arrangements and traveling to be completed.

In spite of all the attention devoted to kidney transplantation, studies have shown that generally less than one percent of all available kidneys nationally are harvested. An intensive effort several years ago in Georgia by staff from the Center for Disease Control was highly successful in increasing the rate of kidney harvesting manyfold.

The State Health Department's Kidney Program has just completed a three-year program laying the groundwork for a similar intensive effort. Implementation will be directed largely at physicians on particular hospital staffs.

The range of possibilities is very broad. An individual physician, or an organization, may tackle the issue. Because of its complexity and likelihood of success, this article will concentrate on the latter. The greatest impact probably can be made directly through a community hospital, especially one with an active emergency room and critical or intensive care unit.

Does your hospital already have a written policy on record for the identification of prospective cadaver kidney donors? If not, will the staff consider writing one? Has there been any recent inservice educational programming on kidney and other organ donation and transplantation? What kind of record has your community hospital established over the past two or three years regarding producing cadaver kidneys?

The Transplantation Society of Michigan will provide information and advice on request (see accompanying address and toll-free long-distance phone number) and has considerable resources to help overcome problems or obstacles to carrying out an effective cadaver kidney donation program.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male 1 Eunuchoidism and eunichism 2 Male climacteric symptoms when these are secondary to androgen deficiency 3 Impotence due to androgenic deficiency 4 Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone These changes appear to be related to dosage of the drug Therefore, in the presence of any changes in liver function tests, drug should be discontinued **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention This may present a problem, especially in patients with compromised cardiac reserve or renal disease In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development Hypersensitivity and gynecomastia may occur rarely PBI may be decreased in patients taking androgens Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements Daily requirements are best administered in divided doses The following is suggested as an average daily dosage guide **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg . Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg ; Postpuberal cryptorchism, 30 mg **REFERENCE:** R B. Greenblatt, M.D., R Witherington, M D., I B Sipahioglu, M D Hormones for Improved Sexuality in the Male and the Female Climacteric, *Drug Therapy*, Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only

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The purpose of this study is to evaluate: 1) The use of Mitotane (op'DDD) in combination with cobalt irradiation to the pituitary gland as primary treatment for Cushing's disease; 2) Once clinical and biochemical remission of Cushing's syndrome has occurred, the duration of remission, incidence of recurrence and development of Nelson's syndrome; 3) Toxicity associated with long-term Mitotane administration; and 4) Mechanism of action of Mitotane (adrenocortical suppression vs suppression of ACTH secretion).

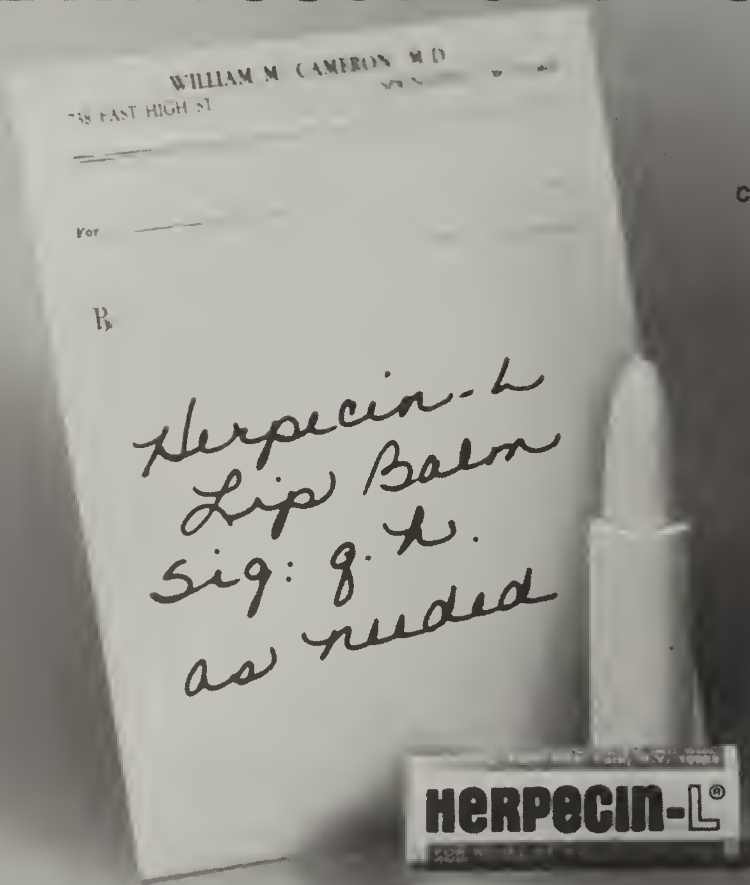
Patients with pituitary ACTH-dependent Cushing's syndrome are being admitted to this protocol for initial evaluation of hypothalamic pituitary adrenal function.

Patients are also evaluated for the presence of a pituitary microadenoma. Patients who are not surgical candidates for transphenoidal pituitary exploration receive treatment with cobalt irradiation of the pituitary gland and Mitotane, in doses of four to six gm daily. Maintenance doses are usually one to two gm daily. Patients are readmitted at three to four month intervals for the following studies: a) Baseline pituitary adrenal function; b) Adrenal response to exogenous ACTH; c) Measurement of biochemical indices possibly affected by Mitotane (laboratory test panel, lipid levels, CBC); d) Measurement of blood levels of Mitotane. Please contact David E. Schteingart, MD, University Hospital, Room S3450, Ann Arbor, 48109. (313) 764-2216.

National Cooperative Study — Plasmapheresis in the treatment of acute Guillain-Barre Syndrome

The University of Michigan, along with 13 other institutions, is cooperating with Johns Hopkins University in evaluating the efficacy of plasmapheresis in the treatment of acute Guillain-Barre Syndrome. Patients 12 years of age or older with symptoms for less than 30 days, moderate weakness, and clinical and laboratory findings consistent with a diagnosis of Guillain-Barre syndrome are eligible. Patients will be randomized into treatment groups consisting of either plasmapheresis or conventional medical management. Patients should not be receiving more than the equivalent of five mgs of Prednisone per day. Plasmapheresis costs are covered by the grant. Please contact James W. Albers, MD, PhD, Department of Neurology, The University of Michigan Medical Center, Ann Arbor, 48109. (313) 764-7170.

Dx: recurrent herpes labialis



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MEDICAL NEWSFRONTS

Home parenteral nutrition program

The University of Michigan Hospital's Parenteral and Enteral Nutrition (PEN) Team (John R. Wesley, MD, chairman) announces its new Home Parenteral Nutrition Program.

Features of the program include: joint and continuous home patient care between the PEN Team and a national pharmacy supply company under the supervision of the referring and/or treating physician. The program is regional in nature. Patients are admitted to the program if they meet the admission criteria set by the PEN Steering Committee. A referring physician may continue to be the primary physician of the patient or may elect for the patient to remain under the care of the admitting physician at the University of Michigan.

Successful Home Parenteral Nutrition requires a strong commitment by the patient and one other family member or close friend acting as backup support. The patient must be capable of independent functioning and judgment. Potential candidates in conjunction with the above criteria include those with Crohn's disease, catastrophic intra-abdominal conditions, short bowel syndrome, severe malabsorptive syndromes and oncology patients who are being actively treated for their disease.

The two-week education and preparation period includes the following:

1. An introduction to basic parenteral nutrition (PN).
2. Placement and care of the permanent central venous catheter including dressing changes and heparinization.
3. Daily monitoring of PN.
4. Identification of possible mechanical, septic, and metabolic complications of PN.
5. Preparation of PN solutions.
6. Cycling procedure to be followed at home.
7. Diet instruction, if indicated.
8. Social and psychological adjustment to HPN.

The PEN Team will continue to be available on a 24-hour-a-day telephone basis for prescription, protocol problems or concerns by either the patient or local physician. Telephone contact will be made monthly or more frequently as needed. The team will see patients during scheduled clinic visits and act as a liaison between the patient and pharmacy supply company.

For more information, write John R. Wesley, MD, chairman, PEN Team, University of Michigan Hospitals, Box 66, Ann Arbor 48109 or call (313) 764-9333.

MPH program

The Department of Medical Care Organization, School of Public Health at the University of Michigan is now accepting application for enrollment into its eighth On Job/On Campus (OJ/OC) class which will begin in the fall of 1983. The OJ/OC program which confers the Master of Public Health (MPH) degree, is offered to professionals employed in the health delivery systems. Former participants have been employed in ambulatory services management, HMO development and operations, health planning, dental public health administration, hospital administration and health manpower training.

Students attend classes in Ann Arbor for one four day weekend every four to five weeks for 25 sessions. Between these monthly meetings, students prepare for class and do work related projects at their site of employment. The program includes courses providing 47 to 49 University of Michigan credit hours covering: managerial tools and approaches useful in health care including financial management and operations research background disciplines to health care administration including health economics, health behavior, organizational behavior and politics of health care; statistics, epidemiology and demography; and medical care organization, administration and financing, ambulatory care, health insurance and medical care law.

Limited financial assistance may be available from the University of Michigan. In addition, loans may be available through the guaranteed student loan program.

For additional information contact:

David Perlman, MPH
On Job/On Campus Program
Department of Medical
Care Organization
School of Public Health
The University of Michigan
Ann Arbor, MI 48109

Depression in the elderly

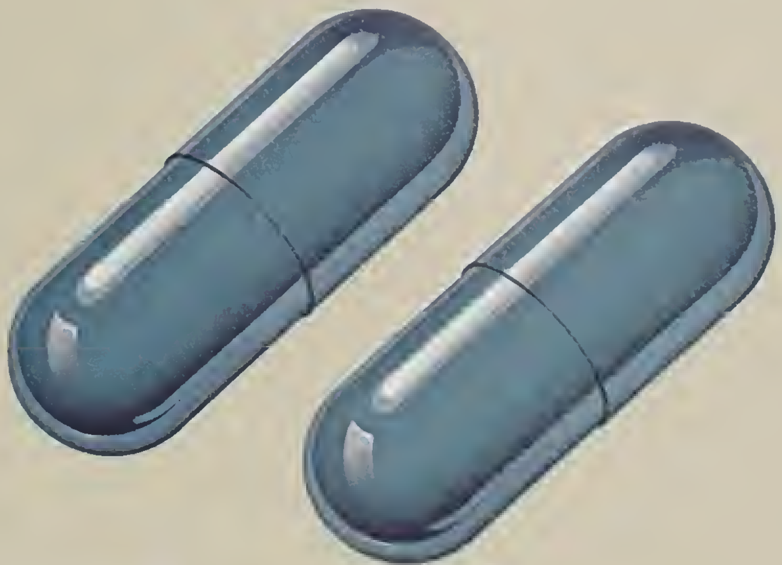
Subjects are needed at Lafayette Clinic in Detroit for a study to establish the efficacy and safety of Zimelidine, a new anti-depressant agent which is chemically different from the tricyclics. The study utilizes a population of geriatric patients.

Zimelidine has been reported to be effective with few or minimal anticholinergic side effects and may be particularly desirable for the elderly. Drug efficacy is evaluated by comparing Zimelidine with desimipramine and placebo in a paralleled group, double-blind design.

Patients who meet DSM III and Research Diagnostic Criteria for Major Affective Disorder will be randomly assigned to one of the three treatment groups. Subjects must be 60-85 years of age; with no clinically significant acute physical illnesses or pre-existing or current psychiatric/neurologic diagnoses.

Following the six week trial period, patients exhibiting favorable therapeutic response may be continued on open label active medication for up to 12 months. Patients assigned to the placebo group during the trial may be switched to open label treatment with Zimelidine following completion of the double-blind trial period.

For referrals, please contact OPD Intake Team, Lafayette Clinic, (313) 256-9569.



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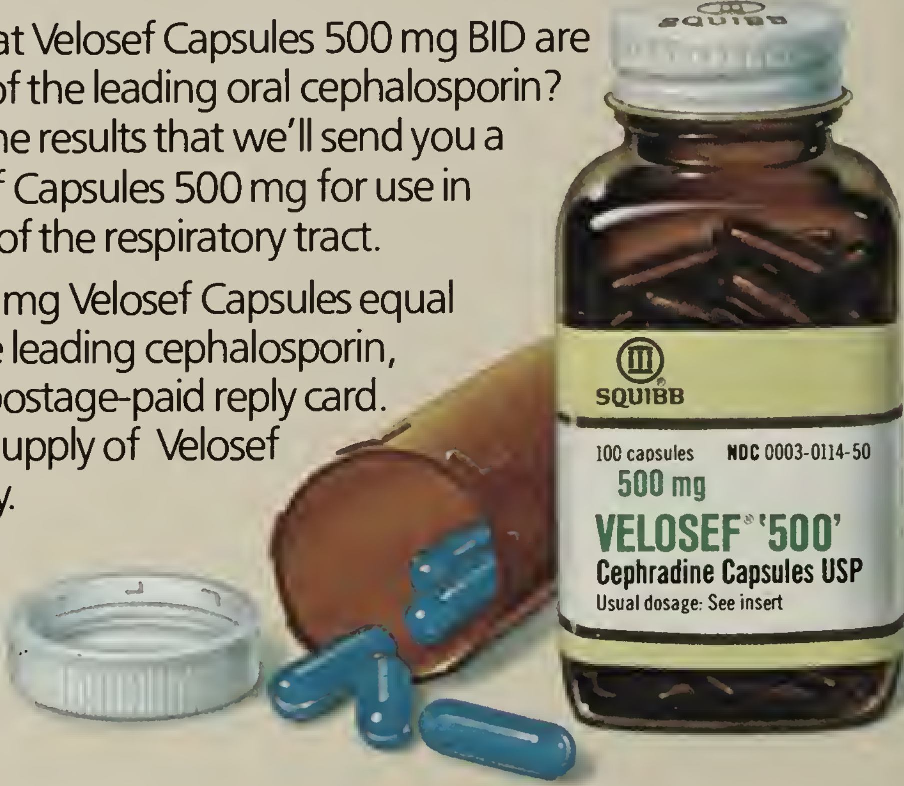

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INDICATIONS AND USAGE: These preparations are indicated for the treatment of infections caused by susceptible strains of designated microorganisms as follows: Respiratory Tract Infections (e.g., tonsillitis, pharyngitis, and lobar pneumonia) due to *S. pneumoniae* (formerly *D. pneumoniae)* and group A beta-hemolytic streptococci [penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever; Velosef (Cephradine, Squibb) is generally effective in the eradication of streptococci from the nasopharynx; substantial data establishing the efficacy of Velosef in the subsequent prevention of rheumatic fever are not available at present]; Otitis Media due to group A beta-hemolytic streptococci, *H. influenzae,* staphylococci, and *S. pneumoniae;* Skin and Skin Structures Infections due to staphylococci and beta-hemolytic streptococci; Urinary Tract Infections, including prostatitis, due to *E. coli, P mirabilis, Klebsiella* species, and enterococci *(S. faecalis).*

Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS; *Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use).* In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephradine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro.* Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis

produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

Diuretics (potent "loop diuretics," e.g., furosemide and ethacrynic acid) — Enhanced possibility for renal toxicity.

Probenecid — Increased and prolonged blood levels of cephalosporins, resulting in increased risk of nephrotoxicity.

Drug/Laboratory Test Interactions: After treatment with cephradine, a false-positive reaction for glucose in the urine may occur with Benedict's solution, Fehling's solution, or with Clinitest® tablets, but not with enzyme-based tests such as Clinistix® and Tes-Tape®. False-positive Coombs test results may occur in newborns whose mothers received a cephalosporin prior to delivery. Cephalosporins have been reported to cause false-positive reactions in tests for urinary proteins which use sulfosalicylic acid, false elevations of urinary 17-ketosteroid values, and prolonged prothrombin times.

Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy: Teratogenic Effects/Impairment of Fertility — Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

ADVERSE REACTIONS: Untoward reactions are limited essentially to G.I. disturbances and, on occasion, to hypersensitivity phenomena. The latter are more likely to occur in persons who have previously demonstrated hypersensitivity and those with a history of allergy, asthma, hay fever, or urticaria.

(continued on next page)

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(continued)

The following adverse reactions have been reported following use of cephradine: G.I. — Symptoms of pseudomembranous colitis can appear during antibiotic therapy; nausea and vomiting have been reported rarely. Skin and Hypersensitivity Reactions — mild urticaria or skin rash, pruritus, joint pains. Blood — mild transient eosinophilia, leukopenia and neutropenia. Liver — transient mild rise of SGOT, SGPT, and total bilirubin with no evidence of hepatocellular damage. Renal — transitory rises in BUN have been observed in some patients treated with cephalosporins; their frequency increases in patients over 50 years old. In adults for whom serum creatinine determinations were performed, the rise in BUN was not accompanied by a rise in serum creatinine. Others — dizziness, tightness in the chest, and candidal vaginitis.

DOSAGE: Adults — For respiratory tract infections (other than lobar pneumonia) and skin and skin structures infections: 250 mg q. 6 h or 500 mg q. 12 h. For lobar pneumonia: 500 mg q. 6 h or 1 g q. 12 h. For uncomplicated urinary tract infections: 500 mg q. 12 h; for more serious UTI, including prostatitis, 500 mg q. 6 h or 1 g q. 12 h. Severe or chronic infections may require larger doses (up to 1 g q. 6 h.).

Children over 9 months of age — 25 to 50 mg/kg/day in equally divided doses q. 6 or 12 h. For otitis media due to *H. influenzae:* 75 to 100 mg/kg/day in equally divided doses q. 6 or 12 h but not to exceed 4 g/day. Dosage for children should not exceed dosage recommended for adults. There are no adequate data available on efficacy of b.i.d. regimens in children under 9 months of age.

For full prescribing information, consult package insert.

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MALPRACTICE CASE HISTORIES

Large percentage of malpractice cases begin right on the medical records

By A. Stewart Kerr
Detroit

Medical malpractice cases, like the weather, are unpredictable. And when a malpractice storm has blown by, the precise reasons for it sometimes are mystifying.

Most Michigan physicians have never seen a malpractice actually tried, nor actually read the transcript of a case that was tried. Their knowledge of particular cases consists largely of hearsay information.

Nonetheless, Michigan physicians *are* interested in malpractice cases — the medical incident that triggers the suit, what happens during the course of the litigation and the ultimate result.

In an effort to satisfy that curiosity, and without pretending to draw meaningful conclusions, this column will present actual Michigan medical malpractice cases, some concluded and some still in process. If empirical conclusions cannot be drawn, at least the reader may look at given circumstances such as record keeping, consultations, and informed consent.

The two trends which require an explanation or exploration are the rapid increase of suits; and the astronomical increase in monetary judgments.

A third trend is not susceptible of proof but the entire ambiance suggests it; namely, that more and more jury verdicts are not so concerned with precedent or justice as they are with balancing the social and economic scales with well-intentioned awards for people who have sustained a medical injury, irrespective of the old questions of tort law such as duty, responsibility and degrees of negligence.

In other words, some decisions seem to be concerned with a perfect standard of care and a substantial, sometimes understandable, concern that no one be exposed to economic disaster.

Mr. Kerr is MSMS legal counsel.

Case history—State of confusion vs. Doctor Klutz

Doctor Klutz is an obstetrician-gynecologist. He had an agreement to cover with another obstetrician-gynecologist, Doctor X. On the morning in question, Doctor X's patient called and told Doctor Klutz that she was in labor. Doctor Klutz told her to come to his office. Doctor Klutz had never seen her before.

On examination, the patient was at approximately 34 weeks gestation (approximately six weeks early). By external landmarks, the fetus was estimated to weigh between four and five pounds. The patient had undergone a cervical cerclage, a technique by which the cervix is sutured shut with a purse-string suturing effect. This is done to prevent the cervix from opening too early, resulting in premature labor.

Doctor Klutz decided on an immediate cesarean section and admitted her for that purpose. The baby developed neonatal distress and died eight months later after $120,000 of specialized care at a specialty hospital. Doctor Klutz realized that he would be sued and accused of rushing the patient to cesarean section too early. Doctor Klutz went to the hospital record room and altered the chart in two critical areas.

Unfortunately, a plaintiff law firm already had the chart!

The original, unaltered examination note reads, in relevant part: "—3 stat" (meaning —3 station, a reference to the position of the fetal head; —3 being two increments higher than —1, etc.). The altered form read: "—3 stat cx. effaced 2cm. dilated bulging membranes." The significance of the difference in station is that a lower head is more dangerous in this context. The patient's cervix had been artificially tied shut to prevent premature labor. Nonetheless, premature contractions are pressing down. The lower the head presentation, the greater the danger of uterine rupture and the more justified it would be to attempt a cesarean section.

The pre-operative progress note also was altered. It was basically a list of the pre-operative indications for surgery. However, the rewritten note is about six lines longer than the original and was an attempt by Doctor Klutz to put into the record, after the fact, a longer list of indications for this surgery than he originally had documented.

This case may be shocking to the medical profession but would not be a stunning surprise to an insurance company. A substantial percentage of malpractice cases is either premised right on the records or, at minimum, originated from interesting records discrepancies.

Appellate Court upholds state arbitration

MSMS legal counsel sends along this summary of a recent Michigan case of interest to MSMS members. The summary first appeared in the "Medical Liability Reporter."

Cushman v. Frankel,
314 N.W.2d 705
(Mich. App. 1982)

A Michigan appellate court has ruled that the state's Medical Malpractice Arbitration Act (MMAA) does not violate the constitutional right to an impartial tribunal, does not promote unknowing waivers of constitutional rights, and does not provide for contracts of adhesion in the form of arbitration agreements.

Plaintiff's decedent entered defendant hospital for treatment and, upon admission, signed an agreement to arbitrate all claims against the hospital. The agreement conformed to the requirements of the MMAA and was not revoked within the 60-day revocation period provided by the Act.

Following her release from the hospital, plaintiff's decedent died and plaintiff brought suit against defendant in state court for alleged malpractice. Defendant moved for accelerated judgment due to lack of jurisdiction. The trial court granted the motion, and plaintiff appealed.

The appellate court affirmed. The court rejected out-of-hand plaintiff's contention tht the arbitration agreement constituted a contract of adhesion, observing that the MMAA requires all agreements to state on their face that execution is not a prerequisite to treatment. Noting also that such agreements are revocable for up to 60 days, the court ruled that the "take-it-or-leave-it" essence of adhesion contracts was lacking.

The court also summarily rejected plaintiff's argument that the agreement constituted an unknowing waiver of constitutional rights, since, by its terms, it certified that the signatory read both the agreement and an accompanying explanatory booklet, and understood the agreement's purpose and effects.

In addressing plaintiff's contention that the MMAA violated due process by requiring that arbitration panels include one physician or hospital administrator, the court acknowledged that the issue was troubling. However, the court concluded that the requirement was not unconstitutional since it provided sufficient safeguards against possible bias in the form of screening of panel candidates by the arbitration association, sworn personal disclosure statements for all panel members, and opportunities for voir dire and challenge-for-cause by the parties.

The end of an attempt at cost control

MSMS Legal Counsel A. Stewart Kerr sends along this synopsis of a recent legal case which, he comments, "has attracted a fair amount of attention over the past two or three years." This is the end, he says, "of an interesting attempt to control costs/fees in an inflating profession."

The Maricopa County Medical Society and others formed two foundations for medical care, nonprofit Arizona corporations composed of MDs, DOs and podiatrists. The members/"participants" (i.e., the various doctors) represent a high percentage of Maricopa County practitioners. The foundations were for the purpose of promoting fee-for-service medicine and to provide a competitive alternative to existing health insurance plans.

These foundations had three functions: to establish the schedule of maximum fees that participating doctors would agree to accept as payment in full for insured patients; to review the medical necessity and appropriateness of the treatment provided, and to draft checks on insurance company accounts to pay doctors for services, as "insurance administrator" per the Arizona Department of Insurance. Participating doctors had no financial interest in the operation of the foundations.

When the lawsuit was filed each foundation was using relative value scales and conversion factors in compiling fee schedules. The fee schedules were periodically revised and the foundations would solicit advice from various societies about changing the relative values and conversion factors. When the foundations formulated new fee schedules they would submit same to the entire roster of participating doctors. In 1980, while the litigation was pending, both foundations discontinued the RVS's and conversion factors. Those devices therefore have no direct bearing on this decision.

No party seriously contended that the fee schedules were not price-fixing. The foundations argued that the schedules imposed a meaningful limit on charges and that advance agreement by the doctors to accept maxima enabled insurance carriers to limit and calculate more efficiently the underwriting risks. The crux of the case was whether the price-fixing was unreasonable and illegal *per se* or whether because of the cost-containment effort and other circumstances the case should go to trial and be adjudicated under the Rule of Reason.

The Court rejected all of the defense contentions: that professionals should not be subjected to a *per se* standard; a lack of judicial antitrust experience with health care precluded application of *per se* principles; and pro-competitive justifications precluded use of *per se* rules. The Court held that this was an agreement among independent competing entrepreneurs and that the situation fits squarely within the horizontal price-fixing rule of illegality. The Court also pointed out the obvious: that fixing maxima is as illegal as agreeing to minima. The peer review and insurance administration aspects did not figure in the decision.

(This case does not create new law and the result is not really surprising. Because organized professional societies are reaching out to find new solutions to peer review and cost containment problems, each such judicial decision in the field is of current interest.)

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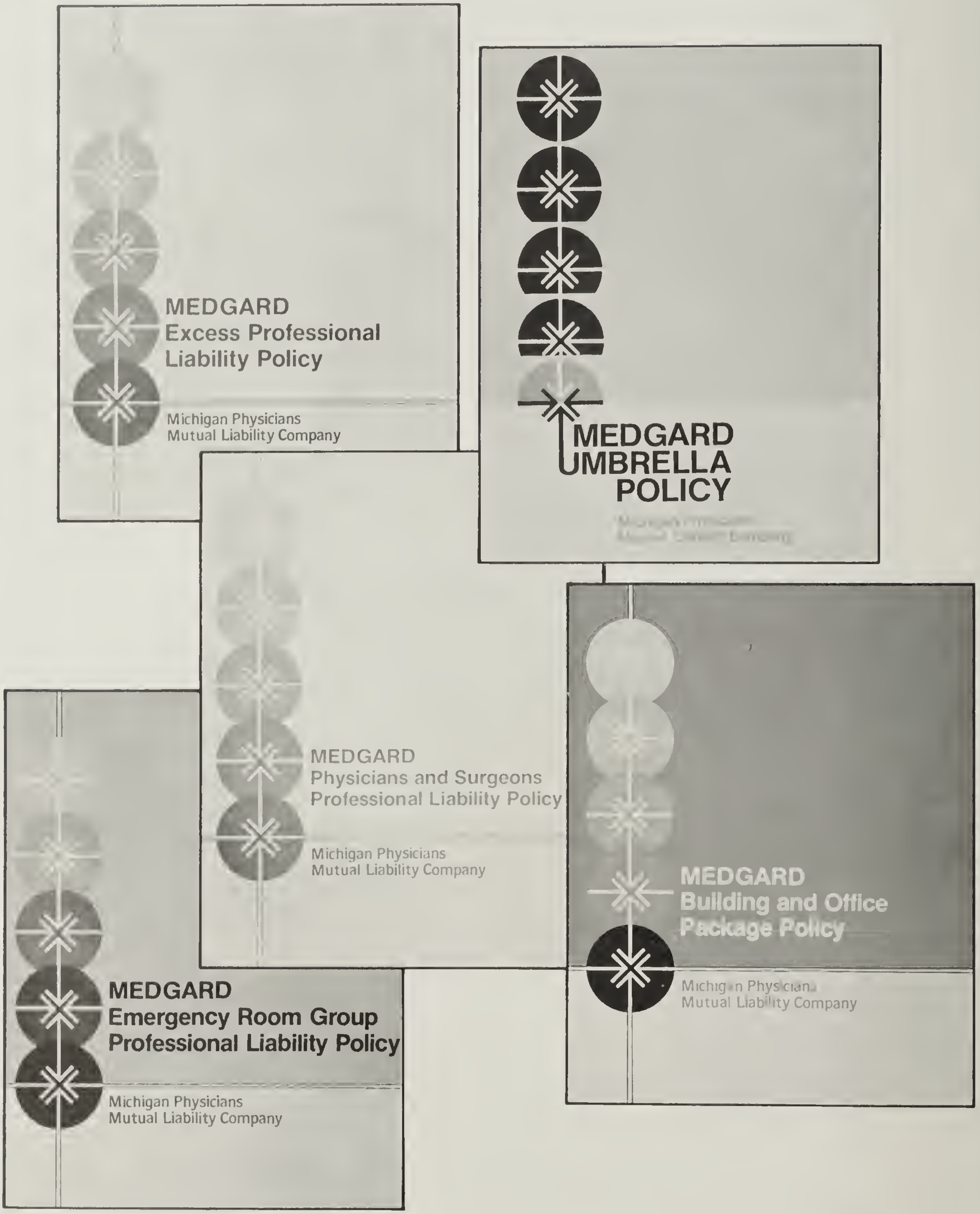

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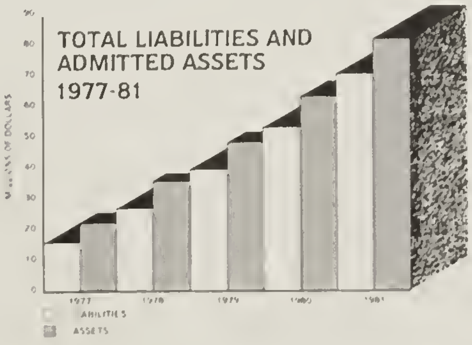

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Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

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MICHIGAN STATE MEDICAL SOCIETY

Legislative alerts: RX for legislative action

By Lillian Fields
Parma

The auxiliary's legislative programs focus on legislative activities as opposed to political activities, which involve the electoral process.

The auxiliary's *Legislative Action Handbook* defines legislative activities as "any action calculated to influence the status of pending bills before a legislative body. Its aim is to mold public opinion and stimulate public action, either favoring or disapproving, on specific legislative issues or philosophic attitudes directly or indirectly concerned with legislative action."

One of the auxiliary's primary vehicles for legislative action is the Legislative Alert System. This system is a valuable and efficient communication network developed by the auxiliary, in conjunction with the medical society, to trigger action on health-related legislation. If a bill needs a lobby response to influence its outcome, the medical society will initiate a legislative alert. Alerts can be for federal or state legislation.

When an alert is sent to the auxiliary, it starts moving through the channels of the Legislative Alert System. Essentially, the structure of this system is that of a pyramid. The chairman of the AMAA Legislative Committee, at the direction of the AMA, relays legislative alert information to the state chairmen. Said state chairmen then consult with their state medical societies for participation, approval and any instructions regarding implementation. When sanctioned, state auxiliary chairmen contact county chairmen who then, with the approval of the county medical societies, alert their sub-chairmen to contact the local auxiliary's "alert participants." Action may be via letter, telephone, telegram or a personal visit to their respective legislators. State legislative alerts filter down to county participants in the same manner.

The contacts that are made between the various levels of chairmen impart information about the bill in question (identification of the bill by name and number, background data, the medical society's position, and the action requested). The county chairman is asked to record action pursued by her auxiliary which is funneled through the state and national auxiliaries and then to the AMA Washington office.

Essential to the system's success is timing. Usually, maximum impact can be made when the bill is in the mark-up phase following committee hearings. Alerts are frequently issued to correlate the "lobby" response in the critical period. Therefore, legislative alerts signal urgent requests and need promptness in answering.

The auxiliary's legislative logo is "Involvement Tips Scales." The slogan "It's Up To You," has been added for the 1982-83 year. The auxiliary is committed to becoming involved. It has the means and potential to influence legislation through its Legislative Alert System. Only the best effort in legislative action will ensure continuing quality medical and health care — for ourselves, our communities and our country.

This is the auxiliary's legislative challenge and goal!

Date to mark and remember: March 9, 1983, Annual State Auxiliary Legislative Day, Civic Center, Lansing, MI.

Mrs. Fields is MSMS-A legislative chairman.

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MATERNAL HEALTH DESK REFERENCE CARD NO. 27

(Sponsored and prepared by the Committee on Maternal and Perinatal Health, Michigan State Medical Society).

PRENATAL DIAGNOSIS

There is an increasing public awareness regarding the availability of techniques involved in the prenatal detection and identification of hereditary diseases or congenital defects.

The physician practicing obstetrics must recognize the need to offer these techniques to pregnant patients at risk and to implement appropriate referrals to genetic counseling and diagnostic centers. *Early* referral is essential.

CANDIDATES FOR REFERRAL:

1. Women 35 years of age or older at the time of delivery or planning a pregnancy.
2. History of previous chromosomally abnormal offspring.
3. Parent(s) with known chromosomal abnormality:
   a. Balanced translocation.
   b. More than one chromosomal cell type (mosaic).
   c. Aneuploidy or trisomy.
4. History of a chromosomally abnormal offspring in a close family member.
5. History of two or more previous spontaneous abortions.
6. History of previous offspring with severe malformations.
7. Known X-linked hereditary disorder.
8. History of previous offspring with autosomal recessive disorder.
9. History of previous offspring, either parent or close relative, with neural tube defect (spina bifida, anencephaly, hydrocephaly).
10. Ethnic associated hereditary diseases (Tay Sachs, Sickle Cell Anemia, Thalassemias).

The most complete and accurate information should be gathered prior to the referral regarding:

1. Thorough history of prospective parents and their families (pedigree).
2. Most complete and accurate diagnoses of any previous congenital anomaly or hereditary disease.

The family's anxiety and attitudes toward prenatal diagnosis may be initially explored by the referring physician. Psychological support is necessary.

A number of diseases may be diagnosed utilizing amniocentesis, which consists of obtaining a sample of amniotic fluid for study. This step is usually performed about 16 weeks of gestation. Accurate estimation of fetal age is mandatory.

RISKS OF AMNIOCENTESIS:

1. Local pain or cramping.
2. Transient amniotic fluid leakage.
3. Infection (0.1%).
4. Abortion (0.5%).
5. Initiate or increase maternal isoimmunization.
6. Unsuccessful attempt:
   a. No fluid is obtained.
   b. Fetal cells fail to grow or maternal cells grow (<1%).
7. Bleeding.
8. Increased chance of fetal needle marks as number of attempts increases.

INFORMATION DERIVED FROM AMNIOTIC FLUID STUDIES:

1. 98% diagnostic success is achieved with an adequate sample.
2. Cytogenetic anomalies are readily identifiable.

3. Approximately 75 serious inborn errors of metabolism can be verified when previous accurate diagnosis is established through history, family pedigree and review of records. This number is rapidly increasing.

The information given to the parents provides them with a definitive basis to anticipate the likely outcome of a given pregnancy.

Determination of alpha-fetoprotein in amniotic fluid is currently offered to all patients who undergo amniocentesis. An abnormal amount of this protein may be related to the presence of an open neural tube defect in the fetus. In these cases, further studies are needed and more specific determinations are available. Special determinations are available to detect fetal hemoglobinopathies. Other special techniques are available in specific cases.

Conclusions:

Once all information is available the referral center will discuss:

A. If the patient is pregnant:
  1. Continuing with the pregnancy; the mother may be referred for follow up and delivery to an institution staffed and equipped to handle the potential maternal-fetal-neonatal complications.
  2. Prognosis according to the alterations in the physical and intellectual development a given child will have.
  3. Potential social and economic implications for the care of the abnormal child.
  4. Request termination of pregnancy and/or permanent sterilization. The mother may be referred to an institution staffed and equipped to handle the best available techniques.
  5. Place the abnormal child for adoption.

B. If the patient is not pregnant:
  1. Suggest and discuss adoption. Refer patient to proper agencies.
  2. Artificial insemination — types and techniques. Refer to proper service, including psychological evaluation and counseling.
  3. Discuss permanent sterilization.

It must be emphasized that in the majority of cases, the fetus is not affected and the concerns and anxieties of the parents are reduced. Amniocentesis is not indicated for all pregnancies and it is not a way to assure parents of the complete absence of fetal defects. When properly utilized, it has greatly assisted in reducing parental fears.

This Reference Card was written for the Maternal and Perinatal Health Committee by Federico Mariona, Detroit, Michigan. (June, 1982)

The above Desk Reference Card describes methods and techniques of clinical practice that are currently acceptable and used by recognized authorities. However, it does not represent official policy or recommendations of the Michigan State Medical Society and its publication should not be construed as excluding other acceptable methods of handling problems.

Worth sharing

From time to time *Michigan Medicine* will reprint excerpts of well-put essays on the current medical scene. The following example was suggested to us by enthusiastic MSMS members who wished to see these comments further disseminated. Have you seen something good lately you would like to share with your colleagues? Please contact the editor, and we will work together to get the good word out.

We all still need an umbrella organization

By Susan Adelman, MD
Detroit

Doctor Adelman

Over the past year, an idea has taken shape within the WCMS that anyone who speaks or votes on an issue should identify clearly what interests they represent. Some have gone even farther. There was even a proposal that any member not speaking for private practice not be allowed to speak. Some would go farther. There is actually a proposal afoot that all physicians not in private practice be defined out of the medical society.

As WCMS president-elect, let me say that the cart is proposing to kick out the horse. First of all, there already exist societies of black doctors, societies of specialists, societies of Indian or Philippine doctors, societies of woman doctors, a Christian medical association, societies of academic physicians, hospital associations, HMO organizations, and numerous other special interest groups. If any physicians are interested in banding together to form an exclusive society of private practitioners, they certainly may do so. What any of this has to do with the structure of WCMS, MSMS, or AMA escapes me.

We all still need an umbrella organization, and that is what the medical society represents. Those physicians who are most embattled need it most, since its size and national structure allow it to represent their interests with the greatest possible clout. The medical society's heterogeneity is actually beneficial, continually forcing one group of members to persuade the others, in an open forum, of the validity of their arguments on any given point. This sharpens their thinking and gives them the benefit of input from their confreres.

Let me make my interests clear. I am in private practice, as private as private can be, by any definition you wish to choose, without torturing and without stretching that definition. I am also female, Jewish, white, a pediatric surgeon, over 40 and under 50. (Let anyone with a personal bias against any of the above so identify himself in any counterstatements.) If I wanted to be properly represented or to properly represent any group, by all rights that group should have all the same characteristics that I have. I submit, though it would be my right to form such a group, that this would be a very small group, with a very small voice. I would still have the right to represent or be represented by a group with as large a voice as possible, however, that group being the WCMS-MSMS-AMA.

After being honored with a position in which as a leader of the WCMS I can speak for the whole profession, I resent the notion that some members can wrap themselves sanctimoniously in their cloak of private practice — the same cloak that I wear incidentally — and assert that I should only represent about half of the profession. This half is to be named the Private Practice section, the latest buzzword for saintliness, and this segment is to be defined as the only one which is interested in Patients — also with a capital P.

I submit that all of us are dedicated first and foremost to the Patient, or we would not be practicing medicine. We all also have personal economic goals, which can be equally intrusive upon or competitive with our patient care goals whether we are in private practice or whether we are hospital-based. Sometimes the interests of specialists (private plus hospital) may appear to be at odds with those of generalists (private or hospital). Sometimes blacks are in conflict with whites. Sometimes the native-born are at loggerheads with FMGs. Sometimes town-gown disputes flare. Sometimes women lodge complaints against men. Sometimes physicians of one religion look askance at those of another.

So what?

The WCMS, MSMS and the AMA represent *all* physicians, and *all* physicians should join and feel welcome. All physicians should feel free to express their views, and all physicians who are not standing to speak ought to be quiet and listen respectfully. Nobody should monopolize the floor, and votes should be democratic. Anybody who wants to form a single interest group should feel free to do so, anywhere else he wants. Has anyone ever heard of *E pluribus unum?*

Toxic Substances Risk Assessment; Elements of Evaluation

By Bailus Walker, Jr., PhD, MPH
Lansing

Doctor Walker is outgoing director, Michigan Department of Public Health. This is the third in a series of articles which he has contributed to *Michigan Medicine* on the subject of environmental health.

Possibly the greatest uncertainty associated with toxic substances management in Michigan involves a process referred to as human risk assessment. This procedure, in its simplest form, is designed to predict the effects on human health of a constant exposure to single or multiple environmental toxicants.

The evaluation of any risk is influenced by two basic factors. How likely is the risk to occur; and if it does occur, how bad will the consequences be?

Two questions

Similarly, there are two fundamental questions to be answered by the risk assessment of a suspected carcinogen or environmental agent which induces neurotoxic effects or chromosome aberrations.

First, how likely is the agent (in water, air, soil or food) to be a human carcinogen? And secondly if it is a carcinogen, how much cancer might be produced by the toxicant if exposure to it is allowed to go on uncontrolled?

Quantitative assessment of human cancer risks may be based on epidemiologic (human) or animal data. In either instance, methodologic problems arise because of the need to extrapolate from effects observed under one condition and level of exposure, and in one population group or biologic system, in order to arrive at an estimate of the effects expected in human groups or individuals. Because extrapolations are involved, uncertainties are necessarily attached to the cancer risk estimates possible using current methodologies.

Despite the uncertainties, risk estimates are being made by regulatory agencies and by other scientific bodies.

For example, recent calculations suggest that some formaldehyde workers face significant risk of cancer. An estimated 620 excess cancers per 100,000 workers could be expected among workers exposed at the current limit of 3ppm. Only 3.5 percent of workers in industries with potential for formaldehyde exposure are exposed at the 3ppm (or above) level. The mean lifetime risk of cancer from formaldehyde exposure could be reduced 27-fold if the maximum exposure limit were cut to that same 1ppm.

Although risk assessment, at this time, represents a highly uncertain science, it is the only means available to quantify the magnitude of risks represented by the *manufacture, use,* and *disposal* of toxic substances and, thus, to permit a comparison of the magnitude of the risks.

Dividing line

Perhaps one of the most difficult aspects of risk analyses is determining the dividing line between *significant* and insignificant risk of disease.

Almost daily the Michigan Department of Public Health and this state's private practitioners of medicine are asked what is the significance of one or .1ppb or ppm of PCB, dioxane or trichloralthylene in drinking water. One view holds that a risk higher than one in 100 should be banned and a risk lower than one in 100,000 should be regarded as trivial.

The US Supreme Court averred that if the odds are one in a billion that a person will die of cancer from taking a drink of chlorinated water, the risk clearly could not be considered *significant.* On the other hand, if the odds are one in 1,000 that the regular inhalation of gasoline vapors that are two percent benzene will be fatal, a reasonable person might well consider the risk unacceptable and take appropriate steps to decrease or eliminate it. The US Food and Drug Administration has determined that a risk of less than 10^{-6} (one in 1,000,000) would be acceptable.

It must be recognized that risk assessment cannot distinguish between risks that are relatively close in magnitude and thus, rigid adherence to specified cut-off levels simply is not feasible at the present.

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NEWS

By Debbie Lange
East Lansing

Doctor Paukstis

Doctor Wade

Joseph A. Barss, MD, vascular surgeon for the St. Clair County area, is a newly-elected member of the Midwestern Vascular Surgical Society. Only 35 Michigan surgeons have been so honored. . . . **Chas A. Paukstis, MD,** retiring after 50 years of practice, was honored in his home in Mason County, with the designation of "Charles Paukstis Day." Recognizing him were the county commission, Ludington City Commission, Scottville City Commission, Rotary Club, Mason County Board of Social Services, Memorial Medical Center, and Oakview Hospital administration and staff. . . . **Janis Pone, MD,** was honored for his 25 years of medical service to the community at a reception given by the board of trustees of Pipp Community Hospital. . . . **John C. McCabe,** president and chief executive officer of BCBSM, was a co-recipient of B'nai B'rith's Great American Traditions Award. This award is given to those whose "life, vision philanthropy, community leadership and outstanding contribution to the social and cultural life of our nation best exemplify the American tradition of selfless service." . . . **Laurence R. Simson Jr., MD,** of the Medical Scientific Advisory Committee for the Mid-Michigan Chapter of the American Red Cross. Doctor Simson also is chief of medical staff at Sparrow Hospital and co-director of the hospital's laboratories. . . . Named director of the U-M Medical School's new cancer pharmacology program is **William D. Ensminger, MD, PhD.** This interdepartmental program includes pharmacology, internal medicine, pediatrics, and other staffs at the U-M College of Pharmacy. . . . **Kenneth J. VanderKolk, MD,** Grand Rapids, is new president-elect of the Central Association of Obstetricians and Gynecologists. Doctor VanderKolk is currently a clinical associate professor in the MSU College of Human Medicine, director of ob/gyn undergraduate training at the Grand Rapids Areas Medical Education Center and director of the ob/gyn residency program at Butterworth Hospital. . . . **Lawrence Crane, MD,** chief of the section of infectious diseases at Harper-Grace Hospitals, has co-authored two papers recently. "Antibiotic Resistance in Anaerobic Bacteria: Molecular Biology and Clinical Aspects," was published in the *Reviews of Infectious Diseases*. "Successful Therapy of Rhinocerebral Mucomycosis with Associated Bilateral Brain Abscesses," is in press for the *Archives of Internal Medicine*. . . . **Richard H. Gascoigne, MD,** is the new MSMS representative to the Michigan Association of the Professions, succeeding Donald K. Crandall, MD, MSMS president-elect. . . . **E. Joseph Alberding, MD,** former MSMS representative to the Michigan Hospice Association, is succeeded by **Cathy O. Blight, MD,** Flint, MSMS Council appointee. . . . The three MSMS nominees, **Arthur S. Elstein, PhD,** East Lansing; **E. J. Potchen, MD,** East Lansing; and **Beverly C. Payne, MD,** Ann Arbor, have been enrolled in the AMA Diagnostic and Therapeutic Technology Assessment (DATTA) Project. DATTA is to assess the diagnostic and therapeutic procedures and techniques that are available, with regard to their benefits, hazards, their effectiveness and their toll. . . . **Franklin V. Wade, MD,** director of trauma at Hurley Medical Center, was the leading fundraiser in the hospital's Biking-for-Burns Bike-a-Thon this past summer. Doctor Wade biked 64 miles and raised $1,056 of the $9,475 collected during the event. . . . **Michael Macksood, MD,** a second-year resident at Hurley Medical Center, was 41st in a field of 1,116 runners at this year's Tuuri 10,000 fundraising road race in Flint. He also was top finisher among a field of 342 Hurley Hospital employees/family members and helped win one of four trophies in inter-hospital competition. . . . **Robert J. Sokol, MD,** is new Hutzel Hospital ob/gyn chief and Wayne State University School of Medicine ob/gyn Department chairman. . . . **Daniel A. De Vries, MD,** is new president of the Pine Rest Christian Hospital Board of Trustees. . . . **Gilbert B. Bluhm, MD,** Southfield, is new president of the Michigan Chapter, National Arthritis Foundation. He has been active in the chapter and foundation for 22 years. . . . **Alejandro Morales, MD,** Grosse Pointe, is new president of the Michigan Dermatologic Society. . . . **Sheikh Saeed, MD,** Detroit, is new vice-chairman of the American Red Cross-Southeastern Michigan Chapter Blood Program Operations Committee. . . . **Donald J. Sherman, MD,** director of occupational medicine at Henry Ford Hospital's Fairlane Center, is new director-at-large of the Michigan Occupational Medicine Association. . . . **Bruce W. Steinhauer, MD,** Detroit, is among the first physicians in the nation to be awarded membership in the American College of Physician Executives. The award is in recognition of excellence in medical practice and management of health care organizations. Doctor Steinhauer is medical director of Satellite and HMO Programs for Henry Ford Hospital. . . . **Louis R. Zako, MD,** Dearborn Heights family physician, is new president of the Michigan Health Council (MHC). Doctor Zako is an active member of the MHC Board and has been president-elect for the past year. . . . **Raymond Bauer, MD,** Grosse Pointe Park, is new president-elect of the Detroit Academy of Medicine. Doctor Bauer is vice-chief of neurology at Harper-Grace Hospitals. He also is new president of the Michigan Neurological Association. . . . **Conrad Lam, MD,** Farmington Hills, was recently honored for 50 years of service with Henry Ford Hospital. Doctor Lam is a consultant with the division of cardiac and thoracic surgery and curator of the HFH Archives. . . . At its 52nd annual meeting, the W. K. Kellogg Foundation reelected two MSMS doctors to three-year terms on the board of trustees. They are **William N. Hubbard, Jr, MD,** of Kalamazoo and **Robert D. Sparks, MD,** of Battle Creek, who also was reelected president and chief programming officer for the Foundation.

Detroit-Macomb Hospital Corporation Presents

Diabetes: Current Concepts, 1983

National authorities present an update on theory and management in the rapidly changing field of diabetes.

Saturday, April 23 **South Macomb Hospital Auditorium, Warren, Michigan**

Program Topics and Faculty

Heterogeneity of Diabetes Mellitus
Stefan Fajans, MD, Director of Michigan Diabetes Research and Training Center, University of Michigan

Insulin Therapy in the 1980s
Lois Jovanovic, MD, Associate Director, Clinical Research Center, Cornell University School of Medicine

Oral Hypoglycemic Agents in the 1980s
Aaron Vinik, MD, Professor of Internal Medicine and Surgery, Division of Endocrinology, University of Michigan

Insulin Delivery Systems: Today's Means and Tomorrow's Prospects
David Schade, MD, Associate Professor of Medicine, Division of Endocrinology and Metabolism, University of New Mexico

Pregnancy and Diabetes
Boyd E. Metzger, MD, Assistant Program Director, Center for Endocrinology, Metabolism and Nutrition, Northwestern University School of Medicine

Defects in Insulin Receptors in Diabetes Mellitus
Jesse Roth, MD, Chief, Diabetes Branch, National Institute of Arthritis, Diabetes, Digestive and Kidney Diseases, National Institutes of Health

Childhood Diabetes: Management Problems
Arlan L. Rosenbloom, MD, Chief, Division of Endocrinology, Professor of Pediatrics, University of Florida College of Medicine

Treatment of Diabetic Retinopathy
Robert N. Frank, MD, Professor of Ophthalmology, Kresge Eye Institute

Seven Hours of Category I Credit
Detroit-Macomb Hospital Corporation, an organization accredited by the Michigan State Medical Society Committee on Continuing Medical Education Accreditation, certifies that this activity meets the criteria for a maximum of seven credit hours in Category I toward the requirements for Michigan relicensure and of the Physician Recognition Award of the American Medical Association provided it is completed as designed.

Registration Fee: $60, including lunch Deadline: April 13

Mail to: Detroit-Macomb Hospital Corporation, Department of Medical Affairs,
7815 East Jefferson, Detroit, Michigan 48214 (313) 821-6000, ext. 270
(Make check payable to DMHC Medical Staff Fund.)

MEETINGS

MSMS, MSMS/A, AMA, and medical assistants

March 2 — MSMS Council, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

March 6 — Medical Assistants State Board Meeting, MSMS headquarters, East Lansing, contact: Caroline Rich, MSMS headquarters, 517/337-1351.

March 9 — MSMS/A Legislative Day, Civic Center, Lansing, contact: Caroline Rich, MSMS headquarters, 517/337-1351.

March 23 — MSMS Conference for Women Physicians, Michigan Inn, Southfield, contact: Sherry Fent, 517/337-1351.

April 6 & 7 — Michigan Conference on Maternal & Perinatal Health, Grand Center, Grand Rapids, contact: Katie Brewbaker, MSMS headquarters.

April 21-24 — Medical Assistants State Annual Convention, Plymouth Hilton, Plymouth, contact: Caroline Rich, MSMS headquarters, 517/337-1351.

April 29-May 1 — MSMS House of Delegates, Hyatt Regency, Dearborn, contact: Richard Campau, 517/337-1351.

May 2-3-4 — MSMS/A 57th Annual Convention, Sheraton Inn, Jackson, contact: Caroline Rich, 517/337-1351.

May 26-27 — Annual Gull Lake Conference, MSMS Committee on Maternal and Perinatal Health, MSU Conference Center, Gull Lake, Kalamazoo, contact: Katie Brewbaker, MSMS headquarters, 517/337-1351.

June 18-23 — Annual Meeting of the AMA House of Delegates, Marriott Hotel, Chicago, contact: Bruce Ambrose, MSMS headquarters.

June 19-22 — AMA Auxiliary Convention, The Drake Hotel, Chicago, IL, contact: Caroline Rich, 517/337-1351.

July 21-24 — MSMS Council Midsummer Meeting, Deer Lake, Boyne Mountain, contact: Warren F. Tryloff, MSMS headquarters.

Sept. 14 — MSMS Council Meeting (Rescheduled from Sept. 21 to Sept. 14), MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Oct. 27 — MSMS Leadership Conference, Long's Convention Center, Lansing, contact: William Madigan or Kevin Kelly, MSMS headquarters, 517/337-1351.

Nov. 15-17 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters, 517/337-1351.

Nov. 23 — MSMS Council, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Other Meetings

March 20-24 — 1983 Annual Meeting, National Association of School Psychologists, Westin Hotel, Detroit, contact: Sharon Pelty, PO Box 55, Southfield, 48037 (313) 851-3229.

April 20-24 — 1983 Annual Meeting, Society for Research in Child Development, Cadillac Hotel, Detroit, contact: Dorothy H. Eichorn, Tolman Hall, University of California, Berkeley, CA 94720, (415) 642-6401.

April 23-26 — 1983 Annual Meeting, Michigan Dental Association, The Westin Hotel, Detroit, contact: Gerri Matelske, 230 N. Washington, Lansing, 48933, (517) 372-9070.

May 19-21 — 1983 Annual Meeting, Michigan Association of Osteopathic Physicians and Surgeons, Inc., Dearborn, contact: D. A. "Tony" Deshaw, 33100 Freedom Rd., PO Box 286, Farmington, 48024, (313) 476-2800.

May 26 — Southwestern Michigan Perinatal Association "Perinatal Potpourri," Western Michigan University, Kalamazoo, contact: Karen Riley, RN, OB Education Coordinator, Memorial Hospital, 2611 Morton Ave., St. Joseph 49085, 616/983-8171.

May 26-31 — American Association for the Advancement of Science, Westin Hotel, Detroit, contact: Ms. Elisabeth Zeutschel, 1101 Vermont Ave. NW, Washington, DC 20005 or Ph: (202) 842-9530.

June 4-7 — 1983 Annual Meeting, Michigan Optometric Association, Boyne Highlands Inn, Harbor Springs, contact: William D. Dansby, Fifth Floor Capitol Bldg., 115 W. Allegan St., Lansing, 48933, (517) 482-0616.

June 5-9 — 1983 Annual Meeting, American Society of Hospital Pharmacists, Cobo Hall, Detroit, contact: Marilyn Sullivan, 4630 Montgomery Ave., Bethesda, MD 20814 (301) 657-3000.

June 22-24 — 1983 Annual Meeting, Michigan Licensed Practical Nurses Association, Amway Grand Plaza, Grand Rapids, contact: Barbara Wells, 5900 Executive Dr., Lansing, 48910, (517) 882-6657.

August 7-11 — 1983 Annual Meeting, National Pharmaceutical Association, Westin Hotel, Detroit, contact: James N. Tyson, PO Box 934, Howard University, Washington, DC 20059 or Ph: (202) 636-7963.

Sept. 6-10 — Association for the Advancement of Medical Instrumentation (AAMI) 1983 Regional Meeting, Detroit, interested participants/cosponsors for 1983 or 1984 meetings should contact: Renee Pietrangelo, AAMI national office, 703/525-4890.

Oct. 6-9 — 1983 Annual Meeting, National Black Nurses Association, Westin Hotel, Detroit, contact: E. Lorraine Baugh, PO Box 18358, Boston, MA 02118 or Ph: (617) 266-9703.

Oct. 10-14 — 1983 Annual Meeting, National Mental Health Association, Hyatt Regency Dearborn, contact: Molly Mannon, 1800 N. Kent St., Arlington, VA 22209 or Ph: (703) 528-6405.

Nov. 10-12 — Michigan Association for Health, Physical Education, Recreation & Dance, Hilton Inn, Traverse City, contact: Sanford Dornbos, Eastern Michigan University, Ypsilanti, 48197, (313) 487-0175.

Nov. 11 — 1983 Annual Meeting, American Medical Women's Association, Dearborn, contact: Carol Meyers, 465 Grand St., New York, NY 10002 or Ph: (212) 533-5104.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517)337-1351.

Date: February 13-18, The Eighth Annual Seminar on Emergencies in Medicine. Location: Boyne Highlands, Harbor Springs. **Sponsor:** Wayne State University School of Medicine, Michigan Committee on Trauma, and Society of Critical Care Medicine. **Cost:** $50. **Contact:** Theresa Sokol, Dept. of Surgery, WSU, 6-C University Health Center, 420 St. Antoine, Detroit 48201 (313) 577-5009. **Approved for:** 22 hours of Category I Credit.

Date: February 14-18, Trauma: The First Three Hours. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, The Section of Emergency Medicine and The Department of Surgery. **Cost:** $475 Physician course fee; $300 Animal Laboratory fee. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 37 hours of Category I Credit.

Date: February 18-19, Practical Otolaryngology. Location: Michigan Inn, Southfield. **Sponsor:** Wayne State University School of Medicine, Department of Otolaryngology. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 4201 St. Antoine, 4H UHC, Detroit, 48201 (313) 577-1180. **Approved for:** 12 hours of Category I Credit.

Date: February 18-20, Advanced Trauma Life Support. Location: Towsley Center for Continuing Medical Education, University of Michigan Medical School, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, The Section of Emergency Medicine, and The Department of Surgery. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor, 48109 (313) 763-1400. **Approved for:** 18 hours of Category I Credit.

Date: March 23, New Technology And Instrumentation In Obstetrics And Gynecology. Location: Saint John Hospital, 22101 Moross Rd., Detroit, 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Obstetrics & gynecology. **Cost:** Physicians $90; Residents, fellows, nurses, allied health professionals, and others $35. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education, (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: March 26-27, Rheumatology Seminar. Location: Sheraton-Southfield Hotel, Southfield. **Sponsor:** Wayne State University School of Medicine, Division of Rheumatology. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 4201 St. Antoine, 4H UHC, Detroit, 48201 (313) 577-1180. **Approved for:** 9.5 hours of Category I Credit.

Date: March 30, Selected Topics in Oral Cavity Carcinoma — A Practical Approach. Location: Sheraton-Southfield Hotel, Southfield. **Sponsor:** Wayne State University School of Medicine, Department of Otolaryngology. **For:** Dental hygienists, dentists, family practitioners, and internists. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 4201 St. Antoine, 4H UHC, Detroit, 48201 (313) 577-1180. **Approved for:** 7.25 hours of Category I Credit.

Date: April 8-10, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, MSU, East Lansing. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: April 15-17, Spring Symposium in Radiation Oncology. Location: U-M Medical Center, Ann Arbor. **Sponsor:** U-M Medical School, Office of Continuing Medical Education, Dept of Postgraduate Medicine and Health Professions Education, and The Dept of Radiation Therapy. **For:** Radiation oncologists, oncologists, radiation therapy technologists, and nurses and physicians involved in the treatment of cancer patients. **Cost:** $295. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 19 hours of Category I Credit.

Date: April 20, Pediatric Acute Care. Location: Saint John Hospital, 22101 Moross Rd., Detroit 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Pediatric. **Cost:** Physicians $90; Residents, fellows, nurses, allied health professionals, and others $35. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education, (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: April 21-22, Perinatology for the Practicing Physician — The Low Birth Weight Infant. Location: Sinai Hospital Department of OB/GYN. **Sponsor:** Mothers and Infants Centers, Sinai Hospital of Detroit. **For:** Obstetricians, perinatologists, pediatricians, neonatologists, nurses. **Cost:** $100. **Contact:** John W. Goldkrand, MD, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 493-6060. **Approved for:** 12 hours of Category I Credit.

Date: April 23, Diabetes: Current Concepts, 1983. Location: South Macomb Hospital, Warren. **Sponsor:** Detroit-Macomb Hospital Corporation. **For:** Internists, endocrinologists, pediatricians, obstetricians, family practitioners and other interested physicians. **Cost:** $60. **Contact:** Detroit-Macomb Hospital Corporation, Department of Medical Affairs, 7815 E. Jefferson, Detroit 48214, (313) 821-6000, ext. 270. **Approved for:** 7 hours of Category I Credit.

Date: April 26, Infectious Diseases Symposium. Location: East Auditorium, Butterworth Hospital, Grand Rapids. **Sponsor:** Butterworth Hospital Medical Education. **Cost:** $40. **Contact:** Erwin J. Haas, MD, Program Director, Butterworth Hospital, 100 Michigan, NE, Grand Rapids, 49503, (616) 774-1835. **Approved for:** 8 hours of Category I Credit.

Date: April 27, Operative Obstetrics II: A Case-oriented Approach. Location: The Towsley Center, Ann Arbor. **Sponsor:** The U-M Medical School, The Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, and The Department of Obstetrics and Gynecology. **For:** Obstetricians, family practitioners, general practitioners, pediatricians, and other health care professionals concerned with care of the obstetric patient. **Cost:** $115. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: May 12-13, Phlebotomy Team: Third Annual Spring Conference. Location: The Towsley Center, Ann Arbor. **Sponsor:** U-M Medical School, Office of Continuing Medical Education, Dept of Postgraduate Medicine and Health Professions Education, and Phlebotomy Services Department of Pathology. **Cost:** $175. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 10 hours of Category I Credit.

Date: May 13-15, Michigan Society of Pathologists' May Seminar. Location: Bay Valley Inn, Bay City. **Sponsor:** Michigan Society of Pathologists. **Contact:** Dr. Willys F. Mueller, Department of Pathology, Hurley Hospital, Flint. **Approved for:** 3 hours of Category I Credit.

Date: May 18, Inflammatory Bowel Disease. Location: Saint John Hospital, 22101 Moross Rd., Detroit 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Surgery. **Cost:** Physicians $90; Residents, fellows, nurses, allied health professionals, and others $35. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education, (313) 343-4877. **Approved for:** 8 hours of Category I Credit.

Date: June 13-17, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Medicine, MSU, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine, Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48823 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: June 15, Geriatrics and Family Practice, Medical and Ethical Decision Making. Location: Saint John Hospital, 22101 Moross Rd., Detroit 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Family Practice. **Cost:** Physicians $90; Residents, fellows, nurses, allied health professionals, and others $35. **Contact:**

Continued on page 120

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(313) 876-1464

CATEGORY I/*Continued*

Linda Campbell, Program Coordinator, Continuing Medical Education, (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: June 21-23, Real-time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: July 18-19, Developing, Marketing, and Managing Conferences: Making It In Tough Times. Location: The Towsley Center, Ann Arbor. **Sponsor:** The University of Michigan Medical School, The Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education. **For:** Those who will develop/manage conferences and need to know how to do it more effectively and economically, whether for universities, hospitals, professional societies, businesses, or hotels. **Cost:** $345. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 12.5 hours of Category I Credit.

Date: Sept. 29-Oct. 2, Sixth Annual Course in Diagnostic Ultrasound. Location: The Towsley Center, U-M Medical School, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **Contact:** Office of Continuing Medical Education, Towsley Center Box 057, University of Michigan Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 24 hours of Category I Credit.

Date: Nov. 1-3, 1983, Real-time Ultrasound Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education. The Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: May 22-24, 1984, Real-time Ultrasound Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

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DEATHS

William L. Doss Jr., MD
Detroit

William L. Doss Jr., MD, a child psychiatrist, was killed in an auto accident November 31. He was 56. Doctor Doss graduated from Howard University's School of Medicine in Washington DC, and later trained in psychiatry at Wayne State University's Medical School. Doctor Doss was a resident of Holly and a staff member of Hurley Medical Center in Flint, Kirwood General Hospital and Southwest Detroit Hospital. He was also a consultant for Wayne County Juvenile Court.

James L. Gillard, MD
Muskegon

James L. Gillard, MD, a Muskegon obstetrician and gynecologist, passed away on December 2 at the age of 76. He was a graduate of Olivet and Dartmouth Colleges and the University of Michigan where he held a residency in obstetrics at the U-M Medical School. He started his practice in Muskegon in 1936, and during his career headed the obstetrical departments of both Hackley and Mercy Hospitals. WWII interrupted his practice upon which he served in the Navy Medical Corps from 1942 to 1945. Doctor Gillard was also a past president of the Muskegon County Medical Society.

Joseph A. Johnston, MD
Birmingham

Joseph A. Johnston, MD, pediatrician at Henry Ford Hospital, died Christmas Day. He was 85. Doctor Johnston graduated from Yale's Medical School in 1923. He was made chief of HFH's pediatrics section at age 30 and was in charge of that department until 1966. He remained on HFH's staff until 1975. During his career, he distinguished himself by publishing more than 60 papers and founding or joining a number of pediatric societies while healing countless children.

Kenneth K. Kimberlain, MD
Grosse Pointe

Kenneth K. Kimberlain, MD, died October 22 at the age of 72. He received his pre-medical education from Hendrix, AR and graduated from the University of Arkansas Medical School in 1935. Doctor Kimberlain was affiliated with Deaconess Hospital of Detroit.

William H. Koehler, MD
Sun City, Arizona

William H. Koehler, MD, obstetrician and gynecologist, passed away November 29, He was 71. Doctor Koehler received his pre-medical education from the University of Michigan and received his medical degree from Northwestern University in 1939. He was affiliated with William Beaumont Hospital of Royal Oak and Woman's Hospital of Detroit.

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DEATHS/*Continued*

Maurice J. Kritchman, MD
Southfield

Maurice Jack Kritchman, MD, surgeon, passed away December 11 at the age of 74. He received his pre-medical education from Wayne State University and received his medical degree from Detroit College of Medicine and Surgery in 1921. In addition, he received an MSC in surgery in 1929 from the University of Pennsylvania. Doctor Kritchman was affiliated with Brent, Park General, and Doctors Hospitals of Detroit.

J.B. Martin Jr., MD
Detroit

J.B. Martin Jr., MD, died November 28. He was 72. Doctor Martin received his medical degree from Meharry Medical College, Nashville, in 1936. He was a founding fellow of the American College of Obstetricians and Gynecologists. He also was affiliated with the obstetrics and gynecology Departments of Crittenton General and Burton Mercy Hospitals of Detroit.

Brita R. McLean, MD
Grosse Pointe Shores

Brita R. McLean, MD, died at her Seabrook Island, SC, home on October 30 at the age of 65. Born in Sweden, she received her pre-medical education from the University of Pittsburg and was a 1942 graduate of North Carolina's Duke University Medical School. She was a member of the Industrial Medical Association and the Michigan Industrial Medical Association. Doctor McLean retired from the medical department of Michigan Bell Telephone Company in 1980.

Russell J. Paalman, MD
Grand Rapids

Russell J. Paalman, MD, a retired obstetrician and gynecologist, died November 11 at his Fort Meyers, FL residence. He received his pre-medical education from Hope College and graduated from University of Michigan's Medical School in 1938. He joined the Army Corps in 1941. He practiced in Grand Rapids from 1947 until his retirement in June of this year. Before retiring, Doctor Paalman was affiliated with Butterworth, St. Mary's, and Blodgett Hospitals. He also was past president of the Central Association of Obstetricians and Gynecologists.

Loren C. Sheffield, MD
West Bloomfield

Loren C. Sheffield, MD, passed away November 19 at the age of 85. He graduated from Rush Medical College of Illinois in 1925. Doctor Sheffield, who at one time was chief of surgery at Pontiac General Hospital, practiced medicine in Pontiac for 40 years until retirement in 1968. He also was affiliated with St. Joseph Mercy Hospital of Pontiac and Lapeer General Hospital of Lapeer. He belonged to numerous specialty societies including the American Urological Society, the American Medical Association and the American College of Surgeons.

Clayton T. Stubbs, MD
Mt. Clemens

Clayton T. Stubbs, MD, a Highland Park ear, eye, nose and throat specialist, passed away November 23. He was 87. Doctor Stubbs was a graduate of the University of Michigan and earned his medical degree in 1919 at the Detroit College of Medicine. He practiced at Highland Park General until retirement in 1967. He was a member of the National Medical Association. Doctor Stubbs also founded and owned the Mount Clemens Race Track until 1977.

Robert B. White, MD
Marquette

Robert B. White, MD, died November 5 at the age of 60. He received his pre-medical education from the U-M Medical School and was a 1954 graduate of Case Western Reserve University of Ohio. He served as a missionary in Zaire from 1958 to 1965. He was a member of Alpha Omega Alpha fraternity and the Christian Medical Society, founder of the Physicians Against Convenience Abortion, and lecturer on "Moral Issues in Medicine" and "A Christian View of Human Sexuality." Doctor White served in General Practice at Bixby Hospital, Adrian, from 1966-1969.

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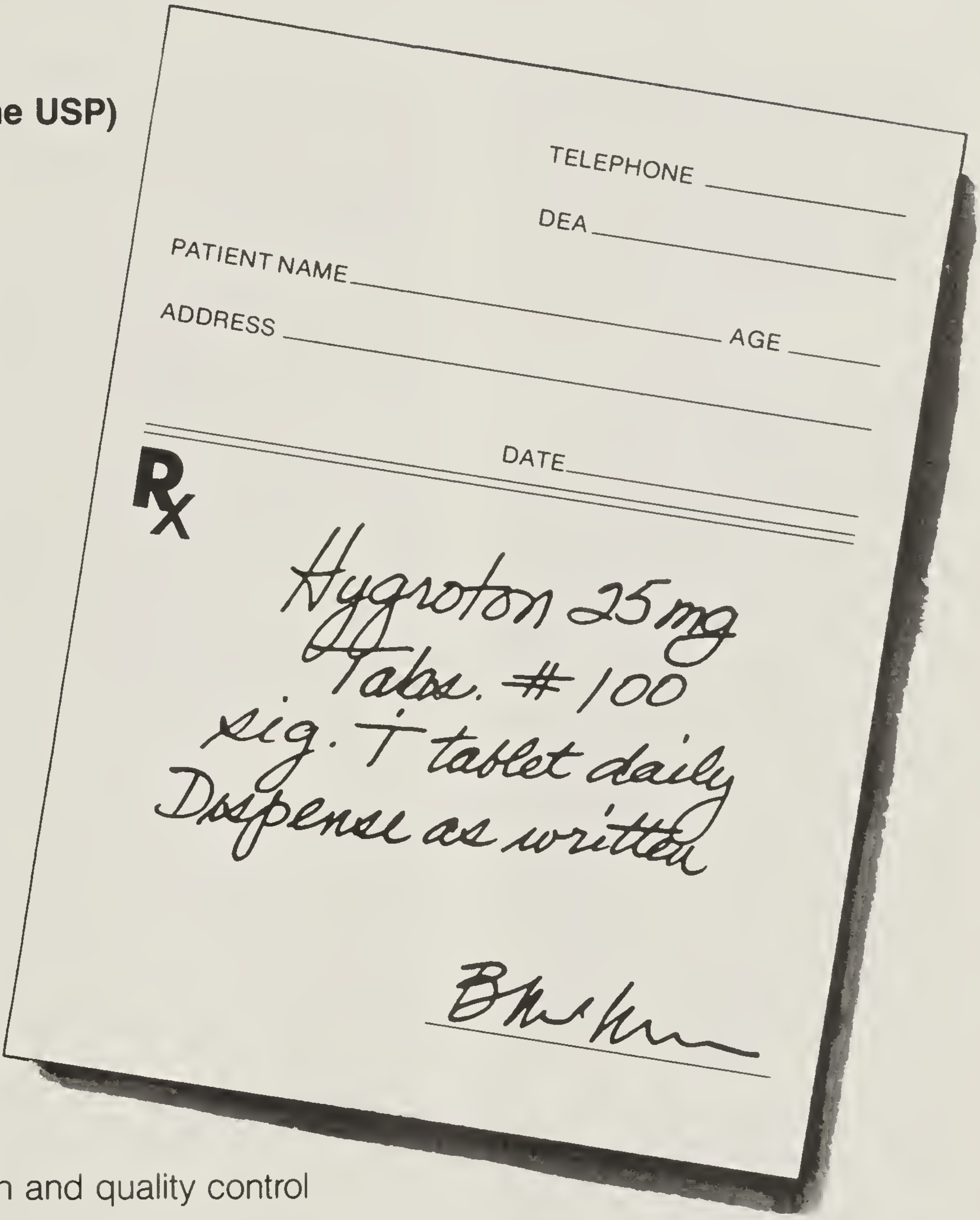

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Precautions: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. All patients receiving chlorthalidone should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Hypokalemia may develop with chlorthalidone as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather. Hyperuricemia may occur or gout be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged and latent diabetes mellitus may become manifest. Chlorthalidone and related drugs may increase the responsiveness to tubocurarine. The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Chlorthalidone and related drugs may decrease arterial responsiveness to norepinephrine. If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic therapy. Chlorthalidone and related drugs may decrease serum PBI levels without signs of thyroid disturbance.
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PRESIDENT'S PAGE

We must continue to work for quality maternal, infant care

By James H. Tisdel, MD
Port Huron

I delivered my first baby in Michigan in 1947. It was a glorious experience and one which has been repeated several thousand times since. I have never regretted my choice to become an obstetrician-gynecologist. The times have been, for the most part, happy ones.

Both MSMS and the American College of Obstetricians and Gynecologists (ACOG) have been important to me and I shall always retain my memberships in both. These organizations are important to my well-being as a physician.

Starting in the mid-50s I had the pleasure of serving on the MSMS Committee on Maternal and Perinatal Health. It was a dynamic, hard working committee then and it remains so today. We will soon approach the 25th anniversary year of the Annual Michigan Conference on Maternal and Perinatal Health. This event continues to grow both in stature and in attendance, thanks to the committee's diligent supervision. The 1983 Conference continues the tradition. And the theme speaks to the issues we face, because even in hard economic times "Michigan Says Yes to Perinatal Care!"

We have a long history of quality maternal and perinatal care in this state. And much of the thanks for this emphasis on quality goes to the MSMS Committee responsible for this excellent series. But I would be remiss not to express my appreciation to the individual practitioners of this state who have labored so conscientiously over the years while continuing to avail themselves of every educational opportunity to improve their skills on behalf of their patients.

I still serve as a member of this excellent committee, but due to the other demands placed upon my time by the Presidency, am unable to actively participate. I'm very comfortable knowing the work of the committee goes on in caring hands and minds. I know that Michigan will continue to enjoy its status as a state where fine maternal and perinatal care are delivered.

At the same time I am confident about the care delivered to mothers and newborns in Michigan, I am concerned about the growing national spectre of the professional liability claims involving brain-damaged children. Despite our best medical and scientific efforts, we continue to experience situations involving brain-damaged newborns.

While some of these incidents may ultimately involve human error in judgment, it is my belief that many of them evolve out of circumstances and/or acts of nature beyond our control. The ACOG Executive Board issued a policy statement in this matter as recently as December, 1982. Yet, with increasing frequency, physicians and hospitals are being held responsible for these unfortunate incidents. The toll on physicians, hospitals, patients and the courts is horrendous.

It is my hope that through the continuing efforts of organized medicine on all levels and by all specialties, but especially by ACOG, that we can find solutions to this problem as well as others surrounding medicine.

The future will challenge us professionally, economically, competitively and legally. I know that through our united efforts we will find solutions to the problems. But most importantly, I believe that we must continue to deliver the highest standards of care in a compassionate, caring manner to our patients. Therein lies the secret of our continuing success.

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References: **1.** Kales A *et al: J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **4.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **5.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Kales JD: *Pharmacol Physicians 4*:1-6, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*:25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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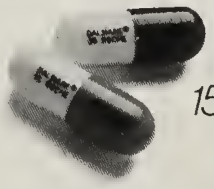
Cont[illegible]rary Hypnotic Therapy

Dalmane® {[illegible]HCl/Roche} Stands Apart

'83

Only one sleep medication objectively fulfills all these important criteria:

- Rapid onset of sleep.[1]
- More total sleep time on the first 3 nights of therapy.[1]
- More total sleep time on nights 12 to 14 of therapy.[1]
- Continued efficacy for at least 28 nights.[2]
- Seldom produces morning hangover.[3]
- Avoids rebound insomnia when therapy is discontinued.[1,4,5]



15-mg/30-mg capsules

Dalmane® Ⓘⓥ

flurazepam HCl/Roche

ROCHE®

Roche Products Inc.
Manati, Puerto Rico 00701

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Please see summary of product information on reverse side.

Vol. 82, No. 9, February 17, 1983

Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

STATE HEALTH CARE BUDGET CUTTERS GETTING TO SPECIFICS

Discussion continues on the health care cuts needed to balance the Michigan budget, despite the fact the governor has not delivered his executive order containing his formal proposals for cuts. Talk is centered in the joint subcommittees for appropriations to the involved state departments. Public health and social services appropriations subcommittees met Feb. 10, with several proposals emerging of interest to physicians.

Public health budget proposals include eliminating state support of family practice residencies, of poison control centers, clinical laboratory licensing and immunization consultation. Subcommittee members suggested reducing support for diabetes and renal disease projects. Legislators' suggestions of interest in social services would affect the Medicaid program and, primarily, hospitals. They include changes in Medicaid interim payments, deferred payments, and a delay in approximately 46 percent of cost settlements to hospitals.

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In the meantime, Republican legislators proposed more than 40 changes, in anticipation of negotiating the governor's proposals. They suggest a hospital benefit limit of 40 days, reduction of Medicaid fee screens by 10 percent, limiting the enrollment in the Primary Care Sponsor Plan to 20,000 persons, and imposing copayments on physician and hospital services.

PHYSICIANS WAITING OUT TEFRA IMPACT

Final regulations are due momentarily under the new Tax Equity and Fiscal Responsibility Act passed in 1982 by Congress. The first impact of TEFRA will be felt primarily by hospital-based Michigan physicians and their colleagues around the country approximately May 1, according to MSMS sources. Of greatest interest to physicians may be the act's effect upon the Medicare program. The MSMS Bureau of Economics has prepared a detailed analysis of the Medicare implications which is available on request. The analysis emphasizes that Medicare regulations now will set monetary caps on reimbursement of the compensation paid by hospitals to hospital-based physicians. The regulations will will eliminate hospitals' potential to receive reimbursement for services in excess of the compensation paid to the physician. TEFRA rules redefine a physician's service, creating a distinction between services to individual patients billed fee for service and physician services to the hospitals based on a supervisory fee. Reasonable compensation equivalents (RCEs) will be determined for both types of reimbursable activities. RCEs will be developed for each specialty and the formula will include location of the service, an inflation factor and number of of hours worked. The final reimbursement will be the RCE limit or the actual compensation, whichever is lower.

MUSKEGON COUNTY REACHES 100 PERCENT MEMBERSHIP LEVEL

MSMS congratulates the Muskegon County Medical Society for achieving 100 percent AMA membership. There are no physicians in Muskegon County who are not members of the federation on all levels. The AMA has sent a letter of congratulations to K. C. Das, MD, immediate past MCMS president, noting that Muskegon County has one of the few "unified jurisdictions" in the nation. The MSMS Membership Recruitment and Retention Committee has issued a challenge to other component societies to match the MCMS achievement in 1983.

In a related development, the MCMS has received statewide attention for reinstating its Deparession-era medical service for the unemployed. The Muskegon program, Doctors Care, is one of several around the state which doctors are initiating to assure that all get medical treatment, regardless of ability to pay.

REGISTRATION ON NOW FOR MSMS MEETING OF WOMEN MDs

All women physicians in Michigan soon will be receiving invitations to the second MSMS conference for women physicians, set March 23 at the Michigan Inn, Southfield. Registration forms are included in the mailing, as well as program details. A highlight of this year's conference will be four breakout sessions morning and afternoon on the topics of professional choices, legislation, media relations, politics, the single woman physician, leadership, the medical marriage and sexual harassment. Details available from Sherry Fent at MSMS headquarters.

CAPSULES

Members of the MSMS Judicial Commission Feb. 9 elected Joseph L. Ponka, MD, Detroit, to a one-year term as chairman. Doctor Ponka formerly served as Commission vice chairman. Edwin R. Guise MD, Detroit, was elected vice chairman. The Commission gave a vote of commendation to recently retired Chairman Harold A. Machin, MD, Kalamazoo, for his dedicated service....Earl G. Moehn, MD, will spend the day in Lansing Feb. 17 as a representative of the MSMS Physician Legislative Network. Doctor Moehn will visit with Macomb County legislators and observe proceedings from House and Senate floors....Openings still exist for MSMS members who wish to join the Michigan Physicians Medical Seminars and ski vacations to Snowmass-at-Aspen March 22-28. A earlier such event Feb. 22-March 1 sold out. For details, contact Richard Campau at MSMS headquarters.

MEDIGRAM

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Vol. 82, No. 9, February 17, 1983

Vol. 82, No. 10, February 24, 1983

Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

FTC order handed down Feb. 18

MSMS LEADERS PLEASED WITH FTC DECISION

MSMS leaders are claiming a victory after initial news of the final order of the Federal Trade Commission issued Feb. 18. The full commission's order is much narrower than the June 1981 order imposed by an FTC administrative law judge, and grants the points sought by MSMS in its appeal before the commission.

"This order represents a vast improvement over the original decree of Judge Howder," said James H. Tisdel, MD, MSMS president, on news of the FTC decision. "I believe we can live with it, if our current understanding is correct, as it permits our organization to act as a responsible part of the health system, which the original order would have precluded."

ORIGINAL ORDER NARROWED

The less stringent order permits MSMS to discuss reimbursement and other issues with third parties, according to an FTC news release, providing such discussions fall short of actually entering into agreements on behalf of members. MSMS specifically is granted the right to talk with Medicaid officials and to participate in peer review of physicians' fees.

"The commission agreed with MSMS that the medical society is a critical part of the health care team, and can discuss cost containment and even reimbursement issues with third parties if such programs are to be effective and not detrimental to the public health," Doctor Tisdel added.

OFFICERS FREE TO EXPRESS OPINIONS

Another positive aspect of the final order apparently permits physician leaders of MSMS to express their opinions as individuals. The original order would effectively have gagged MSMS officers from even speaking to the issues of cost containment and reimbursement programs.

CURRENT ACTIVITIES NOT IN CONFLICT

Current Michigan Department of Social Services regulations and provisions for MSMS involvement in development and operation of the Physician Primary Sponsor Plan in Wayne County are not in conflict with the order. There is no conflict between the order's provisions and the BCBSM enabling legislation which encourages discussions between the Blues and providers.

CHART BEING DEVELOPED

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MSMS is preparing a comparative chart outlining the provisions of the original and anticipated final decree orders, with appropriate explanations and interpretations of the language. MSMS

(Continued back page)

MSMS women MDs conference registration inside

PHYSICIAN PAYMENTS UNAFFECTED BY BRONSON DEPAR SITUATION

Effective Feb. 9, Bronson Hospital, Kalamazoo, became a nonparticipating hospital with BCBSM. Bronson's action will not affect physician reimbursement for professional services. BCBSM subscribers, however, who are patients at Bronson Hospital will incur increased liability for hospital charges at Bronson.

Most BCBSM subscribers will be reimbursed at the rate of $70 per day for non-emergency inpatient services or for services not considered unique to Bronson. Automotive subscribers will be reimbursed at the rate of $100 per day after March 9. At present, emergency (when patient has no choice) and special services available only at Bronson Hospital will be covered in full for all BCBSM subscribers. Special services include burn treatment unit, abortion/sterilization, neonatal intensive care, hemophilia treatment, linear accelerator therapy, hyperbaric oxygen therapy, laser ocular surgery and emergency admissions.

TAXING EMPLOYER'S HEALTH CARE PREMIUMS COULD CONTAIN COSTS

A recently released report by the Rand Corporation indicates that taxing employees for the health insurance premiums paid by their employers could cause Americans to spend considerably less on health care. Federal and state government would definitely benefit by as much as $30 billion for the tax base; health care providers would definitely lose, due to the reduction in services. Employees might or might not be worse off, and health insurers would face large reductions in their volume of business by limiting the favored tax status of health insurance. These tax proposals seek to induce people to shoulder a larger share of their medical bills.

Economists reason that if, instead of being a "free good," premiums are taxed, employees will demand and eventually get cheaper insurance, insurance with higher deductibles and copayments. Policy makers hope that greater cost-sharing will make consumers more cost-conscious and in turn will halt the spiraling growth in health costs.

MEDICAL SCHOOLS AT WAYNE, U-M AMONG LARGEST

Wayne State University School of Medicine and the University of Michigan Medical Schools are fourth and fifth largest in the nation, according to figures published recently by the Journal of the American Medical Association. WSU has 1,008 medical students, and the U-M has 953. The University of Illinois medical school is the nation's largest, with 1,377 students, followed by Indiana University with 1,227 and the University of Minnesota with 1,056 students.

Michigan's three medical schools are in the middle of the pack in costs, however. George Washington University has the highest tuition cost: $19,000 per year. Michigan schools' tuition is in the $4,000 to $5,000 range, which is slightly higher than average for public-supported schools. Texas medical schools have the lowest tuition of the public institutions. They charge just $300-$400 per year for residents; $900-$1,200 for non-residents.

MSMS WOMEN PHYSICIANS CONFERENCE
"WOMEN IN MEDICINE: SURVIVE, SUCCEED, ENJOY"
Michigan Inn, Southfield, March 23, 1983

8:15 a.m. - REGISTRATION/COFFEE

9:00 a.m. - WELCOME/INTRODUCTIONS: Miriam S. Daly, MD, Albion, Chairperson, MSMS Committee on Concerns of Women Physicians

9:15 a.m. - KEYNOTE: "Women in Organized Medicine: How to Get There and Why" Patricia J. Stuff, MD, Past Speaker, State Medical Society of Wisconsin House of Delegates and Delegate to the AMA

10:00 a.m. - BREAK

10:15 a.m. - BREAKOUT DISCUSSION GROUPS: (Concurrent)
A. "The Media" (incl. "how to be interviewed") - Mert Scholten, MSMS Chief of Communications and Vivian Lewis, MD, Flint, MSMS Committee on Concerns of Women Physicians
B. "Legislation" (incl. how to interact") - Winifred Oyen, MD, Midland, MSMS Committee on State Legislation and Regulations and Robert Toteff, MD, Director, Wayne State University Family Practice Residency Program
C. "Hot Political Topics" - Susan E. Adelman, MD, Detroit, President-Elect, Wayne County Medical Society
D. "Professional Choices" - Anna M. H. Broecker, MD, Grand Rapids, MSMS Committee on Concerns of Women Physicians

11:30 a.m. - RE-GROUP FOR PANEL DISCUSSION WITH ALL PRESENTERS

NOON - LUNCH

1:00 p.m. - "Economics and The Woman Physician" - Rhoda Powsner, MD, JD, MSMS Task Forces on Professional Liability and Rate Regulations and Editor, Washtenaw CMS Bulletin

2:00 p.m. - BREAKOUT DISCUSSION GROUPS: (Concurrent)
E. "Medical Family Relationships" - Doctor Miriam Daly and Dawn E. Springer, MD, Mason, Family Practice
F. "Sexual Harassment" - Marguerite Shearer, MD, Dexter, MSMS Committee on Concerns of Women Physicians
G. "Leadership" (techniques and attitudes) - Linda J. Logsdon, MD, Southfield, MSMS Committee on Concerns of Women Physicians and Council, Michigan Psychiatric Society
H. "Single Woman Physician" - Diana Constance, MD, Southfield

3:30 p.m. - RE-GROUP FOR PANEL DISCUSSION WITH ALL PRESENTERS

4:15 p.m. - RECEPTION

REGISTRATION FORM: MSMS WOMEN PHYSICIANS CONFERENCE, Michigan Inn, Southfield, March 23

Name ______________________________
(please print)
Street ______________________________

City, State, Zip ______________________

Tuition Schedule: (check one)
___ $50 Practicing Physician
___ $30 Medical Resident
___ $10 Medical Student
(fee includes lunch)

My choices for the breakout discussion groups are as follows:

MORNING: (please indicate 1st & 2nd choice)

___ A. "The Media"
___ B. "Legislation"
___ C. "Hot Political Topics"
___ D. "Professional Choices"

AFTERNOON: (please indicate 1st & 2nd choice)

E. "Medical Family Relationships"
F. "Sexual Harassment"
G. "Leadership"
H. "Single Woman Physician"

Make checks payable to MSMS and mail to MSMS, Box 950, East Lansing, MI 48823

MSMS/FTC, continued

also is discussing the possibility of holding seminars for component leadership, if necessary, to explain in detail the provisions of the order and the means of compliance.

MSMS OFFICERS, LEGAL COUNSEL DISCUSSING APPEAL

The order apparently allows MSMS to file an appeal within 30 days of receipt of the official document. MSMS leaders and legal counsel are awaiting the order and its estimated 20 pages of interpretations to determine if an appeal of certain elements within the order might be desirable.

"Basically, we are pleased with the provisions set forth in the preliminary document which we have received," comments Doctor Tisdel. "But our legal counsel is examining the order in detail to determine what provisions, if any, might be difficult or onerous to comply with."

CASE STEMS FROM 1977 ACTION

The FTC case arose out of actions taken in a special MSMS House of Delegates meeting in 1977. The House voted then to solicit proxy departicipation letters from MSMS members which would have allowed MSMS to terminate their formal participation agreements with Blue Cross Blue Shield. The effort was made to win the attention of BCBSM, which had unilaterally established drastically different reimbursement profiles for participating and non-participating physicians offering vision and hearing services. Had the programs gone unchallenged, the effect would have been to force all physicians to participate, or suffer the loss of BCBSM subscriber-patients. MSMS members felt those patients were being forced to select participating physicians if they wished the insurer to pay for the vision and hearing services.

MSMS MEETS WITH NEW DIRECTOR OF SOCIAL SERVICES

MSMS had its first official meeting with the new director of the Michigan Department of Social Services today. Meeting with Sr. Mary Agnes Mansour, DSS director, were Allen F. Turcke, MD, Flint, chairman, MSMS Medicaid Liaison Committee; MSMS Director Warren F. Tryloff, and MSMS Staff Bruce Ambrose and Sherry Wellman. The MSMS representatives expected to present Director Mansour with a copy of the MSMS issues paper being distributed to all new state government officials.

MEDIGRAM

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Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

MSMS MEETS WITH MDPH DIRECTOR-DESIGNATE

Introductory meetings are underway between key MSMS personnel and Governor Blanchard's appointees as directors of state government departments. On Feb. 24, Allen F. Turcke, MD, Flint, described the workings of the MSMS Medicaid Liaison Committee he chairs to Sister Agnes Mary Mansour, Department of Social Services director-designate. She told Doctor Turcke and MSMS staff present that the governor's proposed tax increases must be enacted if vital state welfare programs are to continue. Doctor Turcke invited Sister Mansour to attend the next meeting of the MSMS Medicaid Liaison Committee April 6.

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MSMS HOSTS NEW LEGISLATORS

MSMS government relations leaders and staff are hosting a series of get-acquainted receptions for 1983 legislators. The first was scheduled Feb. 28, for new Republican representatives; the the second March 1, for members of the House Public Health Committee, and the third March 7, for incoming Democratic legislators. Presiding for MSMS were Councilor Jack Barry, Saginaw, and Council Chairman Thomas R. Berglund, MD, Portage. Heading the legislative delegations were House party leaders J. Michael Busch, Republican, and Gary M. Owen, Democrat. MSMS plans a reception for new state senators later this spring.

LAWMAKERS BRIEFED ON NEED FOR CHANGES IN MALPRACTICE LAWS

Talks have begun in the legislature over the need for making changes in the state's medical malpractice statutes to meet current needs. The Michigan Chamber of Commerce, member of the Michigan Health Economics Coalition, to which MSMS also belongs, briefed House Insurance Committee members Feb. 23. Chamber representatives are the first to describe the need for legislative revisions in 1983. MSMS is readying introduction of its five-part bill to alleviate physicians' professional liability problems, and hopes to have the bill introduced in March. (That month's issue of Michigan Medicine will present the intent and language of the bill.)

RESIDENT PHYSICIANS FORM MSMS SECTION

A nucleus of the state's resident physicians met Feb. 26-27 at Boyne Mountain ski resort to organize and elect officers of the new MSMS Resident Physician Section. First chairman of the section is Ed Wojtys, MD, Ann Arbor; other officers are David McGreaham, MD, Kalamazoo, vice chairman; and Robert Freedman, MD, Ann Arbor, secretary. Selected delegate to the MSMS House of Delegates is Richard Tooker, MD, Grand Rapids. Section officers will begin recruiting other resident physicians to membership. Interested residents are urged to contact William Madigan at MSMS headquarters.

Register inside for Maternal Health Conference

WEAK UTILIZATION CLOSES FLINT FAMILY HOSPITAL

The closing of the Flint Family Hospital this week is probably due to two major factors, says Genesee County Medical Society President R. A. Dykewicz, MD, Flint. The hospital had been marked for closing for several years due to its low bed occupancy. But despite its rescue via merger with the larger St. Joseph Hospital, the city's recent high unemployment rate probably kept elective patients away. "I believe the economic climate has a lot to do with with bed occupancy figures," says Doctor Dykewicz. "If people here have a job they keep working at it. They would rather work than go to the hospital." Family Hospital, formerly known as Flint General, will maintain an outpatient facility at its present location, and its beds will be counted with St. Joseph's as part of the latter's accredited capacity. "Some of the other hospitals probably are experiencing lessened bed occupancies, too," speculated Doctor Dykewicz in a Medigram interview.

U-M REGENTS VOTE TO REDUCE MED SCHOOL ROLLS

University of Michigan Regents are proposing that the Medical School reduce its 1983 entering class by 30 students, to maintain strength in the face of state funding cutbacks for higher education. The enrollment reduction is to go into effect only if agreement is reached with the state legislature not to reduce support below current levels. The regents hope the enrollment cut, coupled with some moderate tuition increases, will help the school improve its physician-student teaching ratios.

MSMS WORKING ON CHILD ABUSE, HOME HEALTH CARE

Two new MSMS committees are beginning their work to improve the outlook in the areas of child abuse and home health care. The MSMS Task Force on Child Abuse, chaired by Brooker L. Masters, MD, Baldwin, was scheduled to hold its organizational meeting March 1 at MSMS headquarters. It was authorized Dec. 2 by the MSMS Council to study ways in which Michigan physicians could help reduce the incidence of child abuse.

The MSMS Home Health Care Task Force Feb. 24 began its effort to examine the quality of care implications of the trend to increased use of home health care services. Task force chairman is John V. Hartline, MD, Kalamazoo. The committee observed that new Tax Equity and Fiscal Responsibility Act regulations are expected to create an increased demand for home health services.

COUNCIL TO MEET MARCH 2

The new director of the Michgan Department of Management and Budget, J. Phillip Jourdan, was to address the MSMS Council at its regular meeting March 2 at MSMS headquarters. His topic was the status of the state budget. Councilors that day also were scheduled to hear a detailed review of the recent FTC decision in the case of the FTC vs. MSMS, to review proposed guidelines, to help physicians considering preferred provider organizations and to review progress on MSMS nominations to the Blue Cross Blue Shield of Michigan corporate body.

Here is the Maternal Health Conference program and registration form

April 6-7, 1983
Grand Center, Grand Rapids

As an organization accredited for continuing medical education, the Michigan State Medical Society designates this continuing medical activity as meeting the criteria for 13 credit hours in Category I of the CME requirements of the Michigan Board of Medicine. The program has been reviewed and is accepted for 11 Prescribed credits by the American Academy of Family Physicians. Approval is pending with the Michigan Nurses Association for CEU Credit for nurses.

Wednesday morning, April 6

8:30 a.m. "Diagnosis of Sexually Transmitted Diseases in Pregnancy" — David Charles, MD, professor and chairman, Department of Ob-Gyn, Marshall University School of Medicine, Huntington, WV

9:05 a.m. "Diagnosis of the Septic Newborn" — William L. Meadow, MD, assistant professor, Neonatology and Infectious Diseases, Department of Pediatrics, University of Chicago

10:10 a.m. "Management of Sexually Transmitted Diseases in Pregnancy" — David Charles, MD

10:45 a.m. "Management of the Septic Newborn" — William L. Meadow, MD

Noon luncheon meetings

"Regionalized Perinatal Care"
"Antepartum Fetal Monitoring"
"Certified Nurse Midwifery"
"Apnea Monitoring"

Wednesday afternoon, April 6

1:45 p.m. "Ob-Gyn: Responding to Public Demands" — Robert M. Kretzschmar, MD, professor and chairman, Department of Ob-Gyn, University of Missouri-Kansas City

2:30 p.m. "The Status of Bonding — 1983" — Marshall H. Klaus, MD, chairman, Department of Pediatrics, MSU College of Human Medicine, East Lansing

3:45 p.m. "Potential Role of Patient Values and Preferences in Clinical Decision Making" — Marilyn L. Rothert, RN, PhD, director, Lifelong Education, College of Nursing

Thursday morning, April 7

8:30 a.m. "Sexuality and the Pregnant Patient" — Robert M. Kretzschmar, MD

9:15 a.m. "Obstetric Disability: An Employer's Perspective" — Kenneth E. Olthoff, general director, Worldwide Employee Benefits, Personnel Administration and Development Staff, General Motors Corporation

10:30 a.m. "Advising Pregnant Women About Exercise" — Mona M. Shangold, MD, assistant professor of Ob-Gyn, director of Sports Gynecology Center, New York Hospital Cornell Medical Center

Noon luncheon meetings

"Intrapartum Fetal Monitoring"
"Drugs and Pregnancy"
"Certified Nurse Midwifery"
"The Role of the Referring Hospital in Perinatal Transport"

Thursday afternoon, April 7

1:45 p.m. "The Very Low Birth Weight Fetus" — Federico G. Mariona, MD, director, obstetrics and maternal/fetal medicine, Hutzel Hospital/WSU Perinatal Center, Detroit

2:15 p.m. "The Very Low Birth Weight Neonate" — Leonard L. Radecki, MD, co-director, Gerber Neonatal Intensive Care Unit, Butterworth Hospital, Grand Rapids

2:45 p.m. "Ethical Issues in the Treatment of Low Birth Weight Babies" — Howard Brody, MD, assistant professor, family practice and philosophy and assistant coordinator, Medical Humanities Program, MSU College of Human Medicine

3:15 p.m. "Legal Pitfalls in the Treatment of Low Birth Weight Babies" — David J. Cooper, JD, senior partner, Garan, Lucow, Miller, Seward, Cooper, and Becker, PC, Detroit

Advance Registration

Please complete and mail to Michigan Conference on Maternal & Perinatal Health, Box 950, East Lansing 48823

	Wednesday			
	Physician	**Nurse**	**Other**	**Student/ House Officer**
☐ Morning & Afternoon General Sessions	$25	$15	$15	No Charge
☐ Luncheon Meetings (limited to 35 people, indicate 1st & 2nd choices)				
__ Regionalization	$ 8	$ 8	$ 8	$ 8
__ Antepartum Monitoring	8	8	8	8
__ Midwifery	8	8	8	8
__ Apnea Monitoring	8	8	8	8
Wednesday total	$____	$____	$____	$____

	Thursday			
	Physician	**Nurse**	**Other**	**Student/ House Officer**
☐ Morning & Afternoon General Sessions	$25	$15	$15	No Charge
☐ Luncheon Meetings (limited to 35 people, indicate 1st & 2nd choices)				
__ Intrapartum Monit.	$ 8	$ 8	$ 8	$ 8
__ Drugs & Pregnancy	8	8	8	8
__ Midwifery (repeat)	8	8	8	8
__ Perinatal Transport	8	8	8	8
Thursday total	$____	$____	$____	$____

Name ________________________________
Address ________________________________
City ______________ Zip ____________ Phone ____________

Wednesday Total $ ______
Thursday Total ______
GRAND TOTAL $ ______

Checks payable to Michigan State Medical Society

MSMS WISHES JCAH PRUDENCE IN REVISING MANUAL

Following the Jan. 19 MSMS Council meeting, Chairman Fred W. Bryant, MD, of the Council's reference committee on scientific and educational affairs wrote the Joint Commission on Accreditation of Hospitals. Doctor Bryant followed the Council's instructions to inform the JCAH that MSMS opposes changing the term "medical staff" to "organized staff" in the current revision of the JCAH accreditation manual. Here is an excerpt of Doctor Bryant's letter:

"We are aware that medicine and hospitals are under political and legal pressures on all sides, from well-meaning but inept consumer groups, quasi health organizations seeking recognition, competitors trying to improve their positions, traditional friends attempting to usurp areas not their own, and even tensions within our own ranks due to greater numbers and advertising. Yet, in all these things we feel it is best that medicine stand forth clearly in sharp focus. Therefore, we resoundingly endorse retention of the phrase "medical staff" and wish to remain a separate entity; we renounce the phrase "organized staff" and have so indicated..."

Doctor Bryant wished the JCAH "the strength to stand firm where occasion demands, the grace to change when it is timely and beneficial to do so, and prudence to make the right decisions."

CAPSULES

Michigan alternate delegate to the AMA since 1976, George M. Wilson, MD, Marquette, died Feb. 26. He also had been a longtime MSMS delegate....Gerald F. Conway, MD, Royal Oak, was to be in Lansing today to participate in the MSMS Physician Legislative Network's visits to the state capitol. Doctor Conway, president-elect of the Oakland County Medical Society, was to meet with Oakland County legislators Doug Cruce, Phil Mastin, Shirley Johnson, Mat Dunaskiss and Sandy Brotherton....REMINDER: Women physicians who would like to attend the 1983 MSMS Women Physicians Conference March 23 in Southfield will wish to use the registration form which appeared in the Feb. 24 issue of Medigram. Details are available from Sherry Fent at MSMS headquarters.

MEDIGRAM

Michigan State Medical Society
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Editor: Judith Marr

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Vol. 82, No. 12, March 10, 1983

Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

IN THIS ISSUE:
FULL FTC ORDER
IN MSMS CASE

"It is evident...that MSMS has considerable latitude in voicing an opinion for and on behalf of its membership..." observes MSMS Legal Counsel A. Stewart Kerr of the final Federal Trade Commission order in the case of the FTC vs. MSMS. However, he says, that's only so long as that voice doesn't begin to sound like a hardened agreement (or a threat) to fix prices or reimbursement terms for physicians' services.

The order, handed down Feb. 18 in Washington, narrowly defines the boundaries of prohibitions imposed on MSMS by an FTC administrative law judge in June, 1981. At that time, the FTC judge found that MSMS had restrained competition by conspiring with its members to influence the reimbursement policies of health insurance carriers, particularly Blue Cross Blue Shield of Michigan and Medicaid.

MSMS appealed the judge's order to the full Commission and has been awaiting its decision since December, 1981. The Commission heeded MSMS arguments against the severe strictures of the original order and has produced the final order, which MSMS feels it can live with. "The final order, unlike the administrative law judge's order," says Mr. Kerr, "assures a very limited interference with the first amendment rights of MSMS and its members." Its prohibitions, however, he says, are directives from the FTC and should not be considered mere cautionary guidelines.

The full text of the FTC order is printed on pages 2 and 3 of this issue, as required. MSMS members are likely to see the language of the order repeated in official communications over the next several years, in compliance with the order's specifications. The MSMS Council March 3 voted not to appeal the final order, on advice of legal counsel.

MSMS KICKING OFF
SEMINAR SERIES
ON 80s CHALLENGES

MSMS soon will offer a splendid opportunity for members to gain practical knowledge to better cope with the extensive economic changes of the 80s. This opportunity will come in the form of several seminars in locales around the state when experts organized by MSMS will speak on marketing, practice management, financial management, competing forms of health care professionals and the general public. The seminars are the further step in the work begun through the preparation of the MSMS book, "Challenge of the 80s--A Guide to Successful Medical Practice." Following is the seminar schedule:

April 13--Kalamazoo Sheraton Inn
April 21--Lansing Midway Motor Lodge
April 27--Flint Hyatt Regency
May 18--Southfield Michigan Inn
May 25--Grand Rapids Marriott Inn
June 1--Ann Arbor Holiday Inn, West Bank

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FINAL ORDER

This matter having been heard by the Commission upon the appeal of respondent from the initial decision, and upon briefs and oral argument in support thereof and in opposition thereto, and the commission having determined for the reasons stated in the accompanying opinion to deny the appeal of respondent:

It is ordered that the initial decision of the administrative law judge be adopted as the findings of fact and conclusions of law of the commission, except to the extent inconsistent with the accompanying opinion. Other findings of fact and conclusions of law of the commission are contained in the accompanying opinion.

It is further ordered that the following order to cease and desist be, and it hereby is, entered.

I.

It is ordered that for purposes of this order the following definitions shall apply:

A. "MSMS" means Michigan State Medical Society, its House of Delegates, Council, committees, officers, representatives, agents, employees, successors and assigns.

B. "Third-party payer" means any person, corporation, government agency or other entity which agrees to pay for or reimburse all or part of any expense for physicians' services incurred by another person or group of persons. "Third-party payer" includes, but is not limited to, Blue Cross and Blue Shield of Michigan, and Medicaid.

C. "Medicaid" means the program of health care for indigent persons created by Title XIX of the Social Security Act, entitled "Grants to States for Medical Assistance Programs," 42 USC S 1396 et seq. (1976 & Supp. III 1979), including regulations, policies and procedures of Michigan that implement the program in Michigan.

D. "Reimbursement" means money paid by a third-party payer for physicians' services.

E. "Physician" means a doctor of medicine or of osteopathy.

F. "Participation agreement" means any agreement between a third-party payer and a physician in which the third-party payer agrees to pay the physician for the provision of physicians' services and in which the physician agrees to accept payment from the third-party payer for the provision of physicians' services.

II.

It is further ordered that MSMS shall cease and desist from:

A. Entering into or attempting to enter into any agreement or understanding, either express or implied, with any MSMS members to affect or attempt to affect the amount, manner of calculating, or terms of reimbursement, including but not limited to, any agreement or understanding that:

1. any MSMS members will cancel or refuse to enter into participation agreements;

2. any MSMS members will refuse to complete claim forms used by any third-party payer;

3. MSMS can act on behalf of any members through proxy, power of attorney, or otherwise, to cancel or refuse to enter into any participation agreement; or

4. any MSMS members will sign or enter into participation agreements only on terms acceptable to MSMS or to any other MSMS member.

B. Advocating, suggesting, urging, advising, inducing or recommending that any MSMS members engage in any action to affect or attempt to affect the amount, manner of calculating, or terms of reimbursement, including, but not limited to, advocating, suggesting, urging, advising, inducing or recommending that any MSMS members:

1. cancel or refuse to enter into any participation agreement with any third-party payer;

2. refuse to complete claim forms used by any third-party payer.

3. agree to permit MSMS to act on behalf of any MSMS members through proxy, power of attorney, or otherwise, to cancel or refuse to enter into any participation agreement; or

4. sign or enter participation agreements only on terms acceptable to MSMS or to any other MSMS member.

C. Entering into or attempting to enter into any agreement or understanding, either on its own behalf or as representative of any of its members, with any third party payer concerning the amount, manner of calculating, or terms of reimbursement, or concerning the decision of any of its members jointly to accept or reject the terms or conditions of any participation agreement.

D. Making any express or implied threat of acts by any MSMSM members, or engaging in any other acts, with the purpose or effect of coercing, compelling or inducing any third-party payer to accept a position taken by MSMS or any MSMS members concerning the amount, manner of calculating, or terms of reimbursement, or the terms or conditions of any participation agreement.

III.

It is further ordered that this order shall not be construed to prevent MSMS from:

A. Participating in professional peer review of fees charged by individual physicians in individual cases.

B. Exercising rights permitted under the First Amendment to the United States Constitution to petition any federal or state government executive agency or legislative body concerning legislation, rules or procedures, or to participate in any federal or state administrative or judicial proceeding.

C. Providing information or views, on its own behalf or on behalf of its members, to third party payers concerning any issue, including reimbursement.

IV.

It is further ordered that MSMS:

A. Mail a copy of this decision and order to each of its component societies, each of its specialty sections, and a copy of the order to each of its members within 30 days following service of this order.

B. Publish this order in an issue of Michigan Medicine published no later than 60 days after the date the order is served, and in the first Medigram published after the order is served. The order shall be published in the same type size normally used for articles which are published in Michigan Medicine and in the Medigram.

C. For a period of three years, provide each new MSMS member with a copy of this order at the time the member is accepted into membership.

D. Require, as a condition of affiliation with MSMS, that any component society or specialty section agree by action taken by its governing body to be bound by the provisions of parts I-III of this order.

V.

It is further ordered that MSMS shall file a written report with the commission within 90 days of the date of service of this order, and annually on the anniversary date of the original report for each of the five years thereafter, and at such other times as the commission may by written notice to MSMS require, setting forth in detail the manner and form in which it has complied with this order.

It is further ordered that MSMS shall notify the commission at least 30 days prior to any proposed change to itself, such as dissolution, assignment, or sale resulting in the emergence of a successor corporation or association, or any other change which may affect compliance with this order.

COUNCIL MEETS WITH STATE OFFICIALS HOWE AND JOURDAN

The MSMS Council March 3 had the opportunity to talk with two new state administrators. Mrs. Elizabeth Howe, new director of the Department of Licensing and Regulations, told councilors the matter of indemnification of state licensing board members, including Board of Medicine members, is at the top of the list of her priorities and must be dealt with positively. She reviewed her objectives for, and the underfunding of, her department, and promised she would try to reverse the confrontory practices she found when she took office.

State Budget Director J. Phillip Jourdan appeared before the MSMS Council to ask for support of the governor's tax increase proposal. Though the Council did not support the proposal, later that day it did recognize the seriousness of the state's budget problems by approving the following statement: "Physicians represented by the Council of the Michigan State Medical Society recognize the financial ill health of the State of Michigan. Physicians always have and continue to believe in fiscal responsibility, and appreciate that additional revenue is necessary now to achieve a balanced state budget. We believe that as responsible citizens we have no options but to agree that a temporary transfusion and budget cuts are indicated."

At its March 3 meeting, the Council also nominated seven physicians to fill vacancies on the Blue Cross Blue Shield of Michigan corporate body, and four to the BCBSM board. The seven are Susan Adelman, MD; Robert Black, MD; Charles Inniss, MD, and Marion McCall, MD, all incumbents, and all of Detroit; Jay Harness, MD, Chelsea; Robert Herrington, MD, Bad Axe, and Kenneth Rowe, MD, Calumet. The four to the board are Doctors Adelman and Black, incumbents; Inniss, and James Humes, MD, Detroit.

CAPSULES

Richard Czop, MD, Lansing, was to spend the day at the Capitol March 10 as part of the MSMS Physician Legislative Network. Doctor Czop planned to sit in on the House Public Health Committee meeting and join Sen. William Sederburg on the Senate floor....Tuscola County Medical Society members have invited their legislators to their regular meeting March 10. They asked Reps. Richard Allen and John Strand and Sen. James Barcia to discuss current legislation of interest to physicians.

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1983 MSMS House of Delegates

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The still life on the cover this month is composed of objects which are important to the function of the annual MSMS House of Delegates meeting. Here are the delegate's handbook, awards, the 50-year awardees' pins and carnation, the speaker's gavel and election ballots. They all point to the special report in this issue. **(Photo by Mert Scholten, MSMS staff)**

MICHIGAN MEDICINE

March, 1983 Volume 82, Number 13

Special report

132 With the 1983 MSMS House of Delegates meeting fast approaching, it is time to bring the issues forward for discussion. From front to back of this magazine, articles focus on the structure and purpose of the House of Delegates. In the special report section, you will find a discussion of the delegate's role, biographical sketches of the leaders of the House, the plan of business of the coming session and a schematic presentation of how the House of Delegates works; Henry A. Kallet, MD.

Reminder: The deadline for resolutions to be submitted to MSMS headquarters for consideration at the House of Delegates meeting is March 29.

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IN MY OPINION

Get involved! Send a resolution to the House

By Harvey M. Andre, MD
Grand Rapids

Most of us will not be involved directly in the House of Delegates meeting, but questions concerning our methods of practice will be discussed. How we earn our living really is at stake. Many of us may think we have no competition to worry about — or do we?

Are we willing to be part of an HMO? How much do we want to work for an organization? Or would we rather be our own boss, setting our own hours, our own fees, and being selective of the patients we treat?

Do you realize you may be forced to compete with one of your colleagues who is willing to charge less and may be taking your patients away, because he is designated as a "preferred provider" by some insurance group?

These are the types of things on our doorsteps right now, not down the road somewhere. What can we do about them? We can be assured this is our problem, not just a problem of the "big city boys."

The best thing we can do is talk about it with our colleagues — before they are our financial competitors. We can make our ideas known to our county delegates to MSMS. If we think that perhaps an HMO practice, or a preferred provider organization, is our cup of tea, then we should make sure our delegates know what safeguards we would like to control such organizations, so we still will have some freedom of choice in how we practice.

The above are but two examples of the problems facing the medical profession today. How do we feel about satellite clinics, or hospitals competing for patients with a hospital paid staff? How do we feel about PSROs? Do we agree we need some type of peer review, and we should have it through the Peer Review Organization of Michigan, which the doctors control, rather than through some government imposed agency?

These are some of the more prominent issues facing us today. There are many others. We have just received the FTC decision. MSMS also is being brought into the scope of a suit by the chiropodists against BCBSM.

This message is intended to do one thing — to get you to think! Formulate your opinions and communicate them to your delegates, so they may properly represent you. Do it now!

Resolutions must be at MSMS headquarters 30 days before the House convenes on April 29. You don't have much time. Get involved!

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Editor
Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

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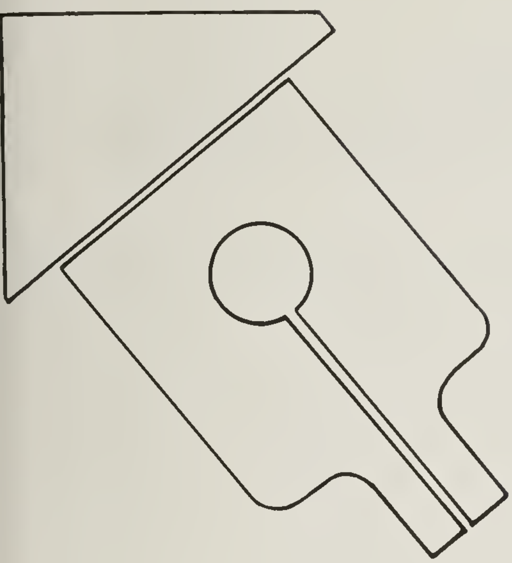
LETTERS



Readers Digest

The letter in the January *Michigan Medicine* concerning the *Readers Digest* account of alleged KGB influence in the Nuclear Peace movement leads me to this comment:

Articles in the *Readers Digest* should not be the basis for forming opinions on foreign policy. President Reagan did just this when he quoted a recent *Digest* article, "The KGB's Magical War For Peace," and gave this as evidence of how "the nuclear freeze movement has been penetrated, manipulated and directed to an amazing degree by people who have but one aim — to promote Communist tyranny by weakening the United States."

By contrast, in December (*after* the above article was published), the House Select Committee on Intelligence issued a 337-page report examining Soviet influence on the American nuclear freeze movement. It concluded that: "Soviet agents have had no significant influence on the nuclear freeze movement."

The President's reasoning was faulty, i.e., that because the Soviets may have infiltrated the U.S. freeze movement, then all freeze proponents are dupes of the Soviets.

Former State Department Spokesperson Hodding Carter pointed out the flaw in the President's logic when he suggested this analogy: "The President has expressed certain positions on civil rights which are identical to positions of the Klu Klux Klan. Does that mean that the President's civil rights stance is Klan-inspired? Or that he is a Klan dupe?"

Why shouldn't the USSR welcome a nuclear freeze? The arms race is as hard on their economy as it is on ours. To think that we can wage a limited nuclear war (as some people in the Pentagon seem to believe) is pure fantasy, and a full scale one would destroy us both.

I am reminded of a delightfully pointed cartoon coming out of Australia. It depicts an American Secretary of Defense complaining to one of his fellows; "The USSR can kill every one of us 15 times over, and we can only kill every one of them 14 times over. See what a menace to us they are!"

John R. Rodger, MD
Greater Kalamazoo PSR

CME by computer

I was pleased to see the conclusion of the Society's task force on continuing medical education and physician competencies, that well meaning attempts to measure competency are not at the same time practical, economically feasible, and necessarily valid for the purpose of relicensure.

Commentary with respect to employment of computers for this purpose suggested to me a thought which might prove to be of benefit to Society members, the State Society itself, and patients whom its members serve. That is, consider the feasibility of setting up a state-wide computer system which could be accessed by a selected sample group of physicians from various specialty backgrounds. This could be broadened to Society members and even other physicians should the concept prove successful. Such a system should incorporate some of the following ideas:

Given a chief complaint, several symptoms and several signs, the computer could be programmed to return a set of differential diagnostic possibilities for a physician to consider. Given certain laboratory values, the program could return diagnostic possibilities along with a table of probabilities, and perhaps one or two suggested clinical features or additional laboratory findings which might be sought to confirm each of these.

Additionally, university centers, hospital or research facilities could contribute information with respect to their special interests, special capabilities, and facilities. Inquiring physicians then could determine, quickly, whom to call for advice on a diagnostic or therapeutic problem, or whom to consider with respect to referral of a patient with a rare condition, or even where some specialized laboratory test or procedure may be obtained.

I am certain that this idea is not necessarily new; it may indeed be impractical, and others may find that there are legal or ethical constraints which might make such a program imprudent. My present thought, however, would be that assistance to physicians who have questions might be accomplished in this manner and that funds expended in such an effort may provide handsome dividends in improved diagnosis, improved therapy, possibly improved membership in the State Society, and improved medical care for residents of the state. It would also seem that funds extended along this line, though initially perhaps requiring a grant from the Society or some interested agency, could be supported on the basis of so-called user fees. I would be interested in hearing from anyone who would have some further thoughts along these lines.

Richard A. Wetzel, MD
Royal Oak

Thank you to MSMS

Thank you for the gift of $2,988 from the Michigan Foundation for Medical and Health Education in support of the College of Human Medicine, for the student emergency loan fund.

On behalf of the board of trustees, I am pleased to express appreciation for this generous investment in Michigan State University.

Cecil Mackey
President
Michigan State University

Continued on page 142

Candidates for nutritional therapy...

10,000,000 alcoholics. Ethanol may produce many effects that together bring about nutritional deficiencies, so that alcoholism affects nutrition at many levels.[1]

25,500,000 geriatric patients. The older patient may have some disorder or socioeconomic problem that can undermine good nutrition.[2]

23,500,000 surgical patients. Nutritional status can be compromised by the trauma of surgery; and some operations interfere with the ingestion, digestion and absorption of food.[3]

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re often provided as a prudent
easure because the vitamin sta-
s of critically ill patients cannot
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THE MULTIVITAMIN/MINERAL FORMULATION

SPECIAL REPORT

MSMS delegates the focal point of their peers' views and opinions

By Henry Kallet, MD
Ann Arbor

What is it like to be a delegate to the MSMS House of Delegates?

I can tell you about that, based on my 13 years' experience in representing my county medical society and now my specialty society.

When does a physician's responsibility as a delegate first begin? Actually, when he or she joins the medical society, as the doctor has the opportunity from the beginning to decide to be an active and informed member.

How do you become this kind of a member?

As soon as you join, you begin receiving the monthly issues of *Michigan Medicine* and the *Journal of the American Medical Association*, and the weekly *Medigram* and *American Medical News* newsletters. These and other printed materials discuss most of the immediate scientific, social and economic problems which concern us all.

If we reflect thoughtfully on what we read and attend component society meetings, we will expand the base of knowledge we need to function as part of organized medicine. Then, we may belong to committees at both local and state levels to develop experience and practical knowledge.

Doctor Kallet is a delegate to the MSMS House of Delegates from the Michigan Society of Pathologists, a post he has held for seven years. Prior to that he served as a county delegate for six years.

Active, involved

A population of active, involved, and knowledgeable members exists in every component society, many of whom have unique expertise. It is from this group that representatives should be chosen to be MSMS delegates.

The delegate must remain in close contact with his or her local medical society. He or she functions to represent the local physicians' attitudes and opinions, and to report the actions of the House and its leadership to the local societies. This is a primary responsibility.

The next responsibility of the delegate is his or her obligation to the district councilor. This is particularly important at the district councilor briefings. This is where we review the resolutions submitted to the House, discuss candidates for future state society offices and explore state-wide issues, particularly those with strong regional overtones.

These resolutions make clear the position of the Michigan State Medical Society and it is through them that the bulk of the work of the House of Delegates is accomplished.

The delegate should emerge from the councilor briefing with an improved knowledge of the important items that will be placed before the House, and by this time should begin to crystallize his or her own thoughts on these matters.

The time of the House meeting finally arrives. Reference committees are chosen from among the delegates and should reflect the special expertise that is present in the House Membership. There is opportunity for spirited debate both in front of the reference committees and in front of the House. It is the job of the reference committee to clarify the resolutions, to combine similar resolutions into a common thought and to pass initial judgement on the validity of each resolution. The ultimate decision and final appeal lie in the hands of the combined delegates.

Early in the meeting caucuses of the delegates meet. These include the Wayne County caucus, the out-state caucus, and, this year, the specialty society caucus, a new group whose members are the delegates elected from the specialty component societies. These caucuses discuss can-

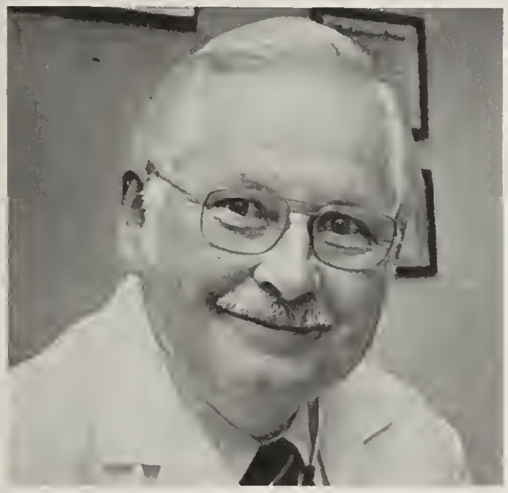
Continued on page 136

They guide the delegates

Gerald H. Mandell, MD
Speaker of the House

Robert D. Burton, MD
Vice Speaker

Henry M. Domzalski, MD
Chairman, Wayne County Caucus



Robert M. Leitch, MD
MSMS Secretary

A. Stewart Kerr
MSMS Legal Counsel

James E. McGillicuddy, MD
Chairman, Outstate Caucus

William B. Jensen, MD
Chairman, Specialty Societies Caucus (photo not available)

Doctor Mandell is a Detroit pathologist and is in his first year as MSMS Speaker. Prior to that, he served as vice speaker for one year. He also is chairman of the MSMS Task Force on Medical Fraud and Abuse and chaired the task force which developed the new MSMS Physicians Review Organization of Michigan. He is a long-time delegate from Wayne County, having served 17 years.

Doctor Burton is a Grand Rapids otolaryngologist. He is in his first term as vice speaker of the MSMS House. He is chairman of the Michigan Coalition for Safety Belt Use, is past chairman of the MSMS Public Service Committee and chairs the Committee on the MSMS Policy Manual. He has been a delegate for 15 years.

Doctor Leitch, a Battle Creek family physician, is past MSMS president and chairman of the Council. He is president of the Michigan Physicians Mutual Liability Company and was instrumental in its founding. He has been MSMS secretary for two years, and served as a delegate for 16 years.

Mr. Kerr is senior partner of Kerr, Russell and Weber, Detroit's oldest law firm and has been chief MSMS legal counsel for 16 years. He also serves on the board of the Michigan Foundation for Medical and Health Education, and is president of the Detroit-area Children's Aid Society and the Metropolitan Council of Churches. His specialty is antitrust litigation; his firm also has represented defendants in hundreds of medical malpractice lawsuits.

Doctor Domzalski, Detroit urologist, is president of the Wayne County Medical Society, which automatically makes him Wayne County Caucus chairman. He has served on the WCMS Council and delegate body, and has been active on the society's Mediation Committee for many years. He was a member of the task force which developed PROM and serves on the MSMS Liaison Committee to the Michigan Department of Public Health. He has been an MSMS delegate since 1963.

Doctor McGillicuddy is a Lansing general surgeon. He serves on the MSMS Committee on Constitution and Bylaws, the MSMS Task Force on Medical Care Costs and the Committee on State Legislation and Regulations. An Ingham County delegate for six years, Doctor McGillicuddy is the son of past MSMS President, the late Oliver B. McGillicuddy, MD.

Doctor Jensen, Grand Rapids anesthesiologist, has served as an MSMS delegate for years. He is a member of the long-time Blue Cross Blue Shield of Michigan Board of Directors and has served as its vice chairman. He is past president of the Michigan Society of Anesthesiologists and has served as an MSMS delegate since 1972.

Here are plans for business of the House

Friday, April 29

4 to 8 p.m. Registration
7:30 p.m. FIRST MEETING

1. Call to order by speaker
2. Invocation
3. Report of Committee on Credentials
4. Reports of the Committee on Rules and Order of Business: Richard H. Gascoigne, MD, chairman
5. Remarks of the speaker: Gerald H. Mandell, MD
6. Memorial service: Robert M. Leitch, MD
7. Introduction of new delegates
8. Remarks of the chairman of the Michigan Delegation to the American Medical Association: Richard J. McMurray, MD
9. Presentations of The Council: Thomas R. Berglund, MD, Chairman
10. Remarks of the president of the Michigan Physicians Mutual Liability Company: Robert M. Leitch, MD
11. Remarks of the chairman of the Michigan Doctors Political Action Committee: Thomas E. Stone, MD
12. Address of the president of MSMS: James H. Tisdel, MD
13. Presidential Citations

Saturday, April 30

8:30 a.m. REFERENCE COMMITTEE HEARINGS —
Reference Committee A — Insurance and Medical Services
Reference Committee B — Legislation
Reference Committee C — Medical Education
Reference Committee D — Hospitals and Medical Facilities
Reference Committee E — Scientific and Public Health
Reference Committee F — Miscellaneous
Committee on Constitution and Bylaws
Committee on Ways and Means

Noon - 1:30 p.m. MDPAC Annual Luncheon, Thomas E. Stone, MD, presiding

1:30 - 2:30 p.m. FORUM — Professional liability

2:30 - 3:30 p.m. Caucuses
Wayne County
Specialty Societies

3:45 p.m. SECOND MEETING

15. Report of Committee on Credentials
16. Nominations and elections
    - (a) Delegates to the American Medical Association
      Incumbents: (Two-year terms)
      Thomas R. Berglund, MD, Portage
      Robert D. Burton, MD, Grand Rapids
      Donald K. Crandall, MD, Muskegon
      Donald N. Sweeny, Jr., MD, East Detroit
      David Siegel, MD, Lansing (Unexpired term — 1984)
    - (b) Members of The Council, MSMS
      Incumbents: (Three year terms)
      Carl A. Gagliardi, MD, Dearborn, 1st District
      James J. Humes, MD, Detroit, 1st District
      Arthur A. Ulmer, MD, Grosse Pointe Shores, 1st District
      Thomas R. Berglund, MD, Portage, 4th District
      Harvey M. Andre, MD, Grand Rapids, 5th District
      Richard L. Rapport, MD, Flint, 6th District
      Dean P. Carron, MD, Ann Arbor, 14th District
    - (c) Secretary, Assistant Secretary, Treasurer and Assistant Treasurer (Nominated by The Council — MSMS Bylaws, Chapter 9, Section 12)
    - (d) Alternate Delegates to the American Medical Association
      Incumbents: (Two year terms)
      Gerald H. Mandell, MD, Detroit
      Carl A. Gagliardi, MD, Dearborn
      Billy Ben Baumann, MD, Pontiac
      Robert E. Paxton, MD, Fremont
      In addition, two additional alternate delegates must be elected due to increase in Michigan AMA members. (Two-year term, one-year term)
    - (e) Speaker of the House of Delegates
      Incumbent: Gerald H. Mandell, MD, Detroit
    - (f) Vice-Speaker of the House of Delegates
      Incumbent: Robert D. Burton, MD, Grand Rapids
    - (g) President-Elect
17. Presentation of Awards
    AMA-ERF Grants to Michigan Medical Schools by MSMS Auxiliary President
    Flag Awards
    National President Awards
    50-Year Awards
18. Election Results
19. Installation of Incoming President
20. Remarks of President Donald K. Crandall, MD

6:30 p.m. Reception and Banquet Honoring the MSMS Presidents

Sunday, May 1, 1983

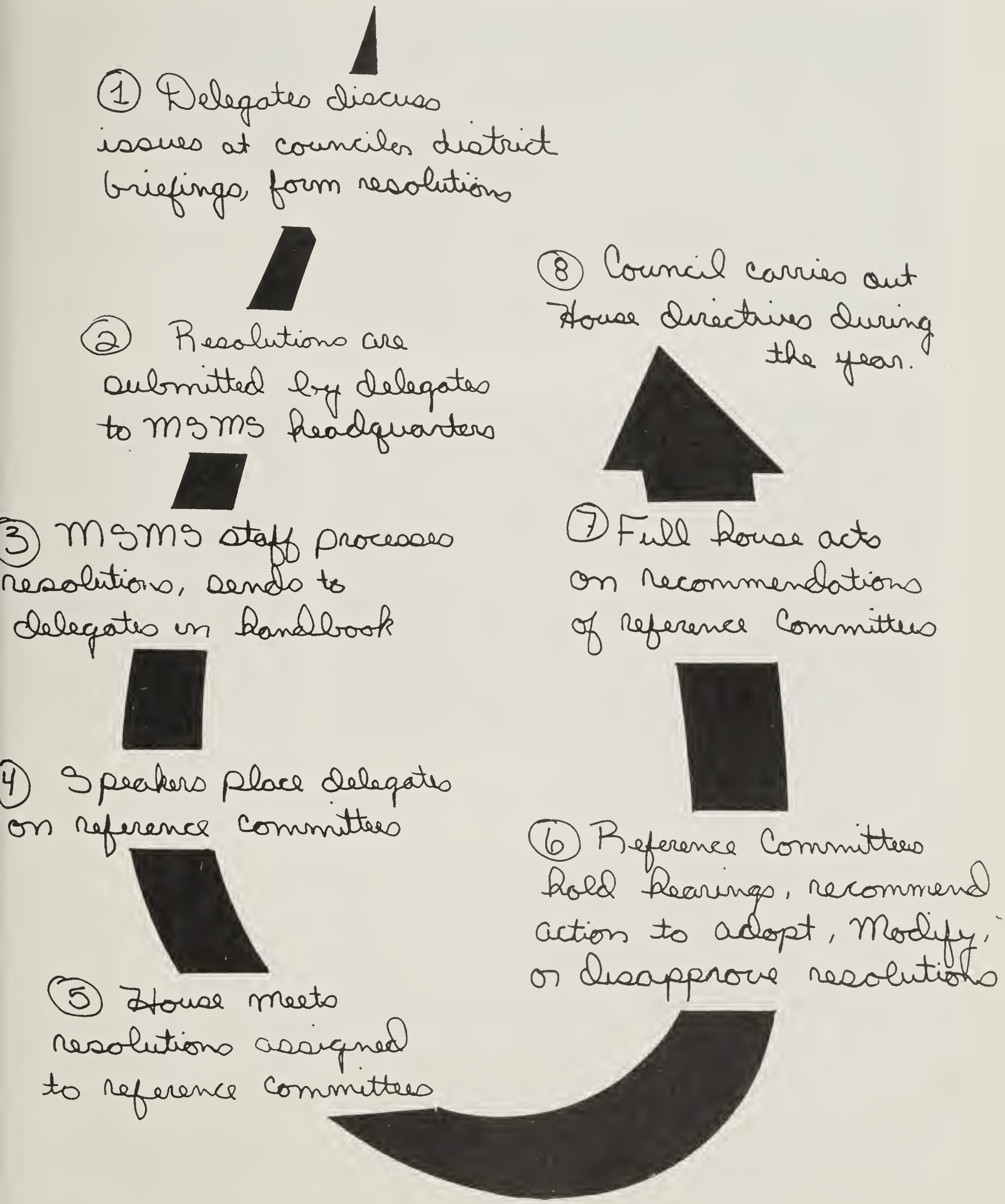
9:30 a.m. THIRD MEETING

21. Supplemental report of the Committee on Credentials
22. Reports of reference committees

2:00 p.m. FOURTH MEETING

23. Supplemental report of the Committee on Credentials
24. Reports of reference committees
25. House of Delegates adjournment

How an idea becomes official MSMS policy; or, how the House of Delegates works



① Delegates discuss issues at councilor district briefings, form resolutions

② Resolutions are submitted by delegates to MSMS headquarters

③ MSMS staff processes resolutions, sends to delegates in handbook

④ Speakers place delegates on reference committees

⑤ House meets resolutions assigned to reference committees

⑥ Reference Committees hold hearings, recommend action to adopt, Modify, or Disapprove resolutions

⑦ Full house acts on recommendations of reference Committees

⑧ Council carries out House directives during the year.

Scenes of recent House meetings

1981— Doctor Fryfogle stoops to receive past president's medal from Doctor Ylvisaker.

1979— Genesee County Delegate Richard J. McMurray, MD, waits to testify on floor of the House as Wayne County Delegate Robert W. Black, MD, takes his turn.

1980— MSMS President James D. Fryfogle, MD, right, escorts new President-Elect John R. Ylvisaker, MD, to front of House.

1982— MSMS Secretary Robert M. Leitch, MD, gives oath of office to incoming President James H. Tisdel, MD.

DOCTOR KALLET/*Continued*

didates and issues on a broad regional basis. Further, representatives of the various caucuses meet to coordinate and ease the progress of issues and candidates as they are presented to the full house.

Experience is the best teacher. The novice delegate will have to attend several caucuses before becoming totally comfortable with the system.

Fun, too

Not every moment is spent in hard work. Hospitality suites of various organizations allow relaxation from the rigors of the meetings and permit old friends to meet and review the past years' accomplishments. A high point of the meeting is the incoming president's reception where all of the new officers are introduced and the out-going members are thanked for their efforts on behalf of the society.

All of these activities will sound formidable to the new delegate. If one were to give any advice to the novice in preparation for a first House of Delegates meeting, the following points should be emphasized:

1. Come prepared. Know the issues.

2. Meet with prospective candidates for state-wide office. Take the time to learn their positions on the various questions in front of the House.

3. Consult with your peers at home before the meeting to ensure that you reflect their opinions and their views. If necessary, be the focal point that crystallizes the views and opinions of your local colleagues.

4. Perhaps the best advice of all — make sure the brain is running before putting the mouth in gear.

Michigan specialty society officers

Michigan Allergy Society
President: Murray O'Neil, MD, 1100 Ouellette, Windsor, Ontario, Canada N9A1C9
Secretary: A. Sosin, MD, 23023 Orchard Lake Rd., Farmington 48024

Michigan Society of Anesthesiologists
President: Michael J. Curtin, MD, Route 2, Box 94, Gladstone 49837
Secretary: Sidney Soifer, MD, 17115 Shervilla, Southfield 48076

Michigan Chapter, American College of Chest Physicians
President: Meryl M. Fenton, MD, 26771 W. 12 Mile Rd., #110, Southfield 48034
Secretary: William A. Conway, MD, Henry Ford Hosp., 2799 West Grand Blvd., Detroit 48202

MSMS Section on Clinical Pharmacology and Therapeutics
President: George L. Royer, Jr., MD, Upjohn Company, Kalamazoo 49001
Secretary: J. Richard Goulet, MD, 2800 Plymouth Road, Ann Arbor 48106

Michigan Society of Colon and Rectal Surgeons
President: W. Patrick Mazier, MD, 72 Sheldon Blvd., S.E., Grand Rapids 49503
Secretary: Hans Stein, MD, 1121 Crooks Rd., Royal Oak 48067

Michigan Dermatological Society
President: Alejandro Morales, MD, 1015 Fernwood, Royal Oak, 48067
Secretary: Margaret Douglass, MD, 1015 Fernwood, Royal Oak 48067

Michigan Chapter, American College of Emergency Physicians
President: Paul R. Pomeroy, Jr., MD, 1305 Abbott Road, Suite 109, East Lansing 48823
Secretary: Robert D. Aranosian, DO, 1305 Abbott Road, Suite 109, East Lansing 48823

Michigan Academy of Family Physicians
President: Harold F. Kendrick, MD, 109 E. Oakland, Lansing 48906
Secretary: Charles E. Morrill, MD, 109 E. Oakland, Lansing 48906

Michigan Society for Gastrointestinal Endoscopy
President: Ramon R. Joseph, MD, Wayne Co. General Hosp., Eloise 48132
Secretary: Harold Tobes, DO, 13552 Martin, Suite A, Warren 48093

Michigan Society of General Surgeons
President: John C. Rienstra, MD, 21 Michigan, NE, Grand Rapids 49503
Secretary: James W. Copping, MD, 2601 Electric, Port Huron 48060

Michigan Health Officers Association
President: Winifred A. Oyen, MD, 125 West Main Street, Midland 48640
Secretary: Edwina Engel, MDPH, 3400 North Logan, Lansing 48909

Michigan Society of Internal Medicine
President: Hector J. Inchaustegui, MD, 4045 W. 13 Mile Road, Royal Oak 48072
Secretary: Francis Horvath, MD, 2909 E. Grand River Ave., Suite 215, Lansing 48912

Michigan Neurological Association
President: Raymond B. Bauer, MD, University Health Center, 4201 St. Antoine 6G, Detroit 48201
Secretary: Foster Redding, MD, 18430 Mack Avenue, Grosse Pte. Farms 48236

Michigan Association of Neurological Surgeons
President: Paul D. Croissant, MD, 1431 Woodward Avenue, Bloomfield Hills 48013
Secretary: William F. Chandler, MD, U of M Medical Center, Ann Arbor 48109

Michigan College of Nuclear Medicine Physicians
President: Ronald Petrocelli, MD, St. Joseph Mercy Hosp., Huron River Dr., Ann Arbor 48106
Secretary: Conrad E. Nagle, MD, William Beaumont Hosp., 44201 Dequindre, Troy 48098

Michigan Section, American College of Obstetricians and Gynecologists
President: Bruce H. Drukker, MD, Henry Ford Hospital, 2799 West Grand Blvd., Detroit 48202
Secretary: James Gell, MD, 2520 S. Telegraph, Bloomfield Hills 48013

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Michigan Occupational Medical Association
President: Monroe S. Lechner, MD, Ford Motor Co., CMS Bldg., 3001 Miller Rd., Dearborn 48121
Secretary: Howard J. Sawyer, MD, 32736 Northwestern Highway, Farmington Hills 48018

Michigan Ophthalmological Society
President: Jerome D. Davis, MD, 29927 W. Six Mile Rd., Livonia 48152
Secretary: Hugh Beckman, MD, 26206 W. 12 Mile Rd., Southfield 48034

Michigan Orthopaedic Society
President: John Wagner, MD, 19495 Mack Ave., Grosse Pointe Woods 48236
Secretary: John Henke, MD, 3115 Professional Dr., Ann Arbor 48103

Michigan Oto-Laryngological Society
President: Walter M. Belenky, MD, Children's Hospital of Michigan, 3901 Beaubien St., Detroit 48201
Secretary: Arnold M. Cohn, MD, Wayne State University, 4201 St. Antoine, Detroit 48201

Michigan Society of Pathologists
President: Sheldon F. Markel, MD, St. Joseph Mercy Hospital, P.O. Box 995, Ann Arbor 48106
Secretary: Willys F. Mueller, Jr., MD, Hurley Medical Hospital, 1 Hurley Plaza, Flint 48502

Michigan Chapter, American Academy of Pediatrics
President: Robert S. Holm, MD, 1521 Gull Road, Kalamazoo 49001
Secretary: Natalia M. Tanner, MD, 4727 St. Antoine, Suite 303, Detroit 48201

Michigan Academy of Physical Medicine and Rehabilitation
President: Myron LaBan, MD, 3535 W. 13 Mile Rd., Suite 703, Royal Oak 48072
Secretary: Thomas E. Szymke, MD, 6767 West Outer Drive, Detroit 48235

Michigan Chapter, American College of Physicians
Governor: Arnold R. Axelrod, MD, 14800 W. McNichols, Detroit 48235
Secretary: A. Martin Lerner, MD, Hutzel Hospital, 4707 St. Antoine, Detroit 48201

Michigan Academy of Plastic Surgeons
President: William D. Simpson, MD, 1900 Wealthy S.E., Grand Rapids 49506
Secretary: M. Haskell Newman, MD, 3075 Clark Rd., Suite 210, Ypsilanti 48197

Michigan Psychiatric Society
President: Joseph Fischhoff, MD, 3901 Beaubien, Detroit 48201
Secretary: Robert D. Woodward, MD, 555 South Woodward, Suite 610, Birmingham 48011

Michigan Psychoanalytic Society
President: Ronald M. Benson, MD, 2200 Fuller Road, #203B, Ann Arbor 48105
Secretary: Evangeline J. Spindler, MD, 555 E. William, #17K, Ann Arbor 48108

Michigan Radiological Society
President: David P. Corbett, MD, Children's Hosp. of MI, 3901 Beaubien, Detroit 48201
Secretary: Forrest J. Arnoldi, MD, 3800 Woodward Ave., LL 14, Detroit 48201

Michigan Chapter, American College of Surgeons
President: Charles E. Lucas, MD, 4201 St. Antoine, Detroit 48201
Secretary: James C. Stanley, MD, 405 E. Ann St., Ann Arbor 48109

Michigan Society of Therapeutic Radiologists
President: Harold Perry, MD, Sinai Hosp., 6767 W. Outer Dr., Detroit 48235
Secretary: Basil Considine, Jr., MD, South Macomb Hosp., 11800 E. 12 Mile Rd., Warren 48093

Michigan Society of Thoracic Surgeons
President: Robert W. Harrison, MD, 1900 Wealthy St., Grand Rapids 49506
Secretary: Rodman E. Taber, MD, Macomb Professional Bldg., #301B, 11885 12 Mile Rd., Warren 48093

Michigan Branch, American Urological Association
President: Joseph C. Cerny, MD, Henry Ford Hosp., 2799 West Grand Blvd., Detroit 48202
Secretary: R. Lawrence Kroovand, MD, Children's Hosp. of Michigan, 3901 Beaubien, Detroit 48201

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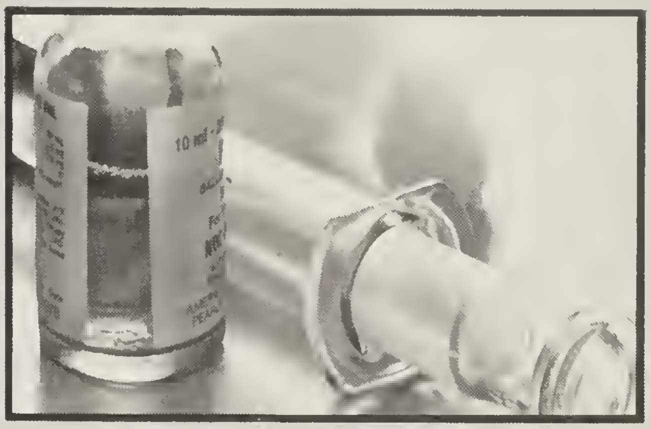

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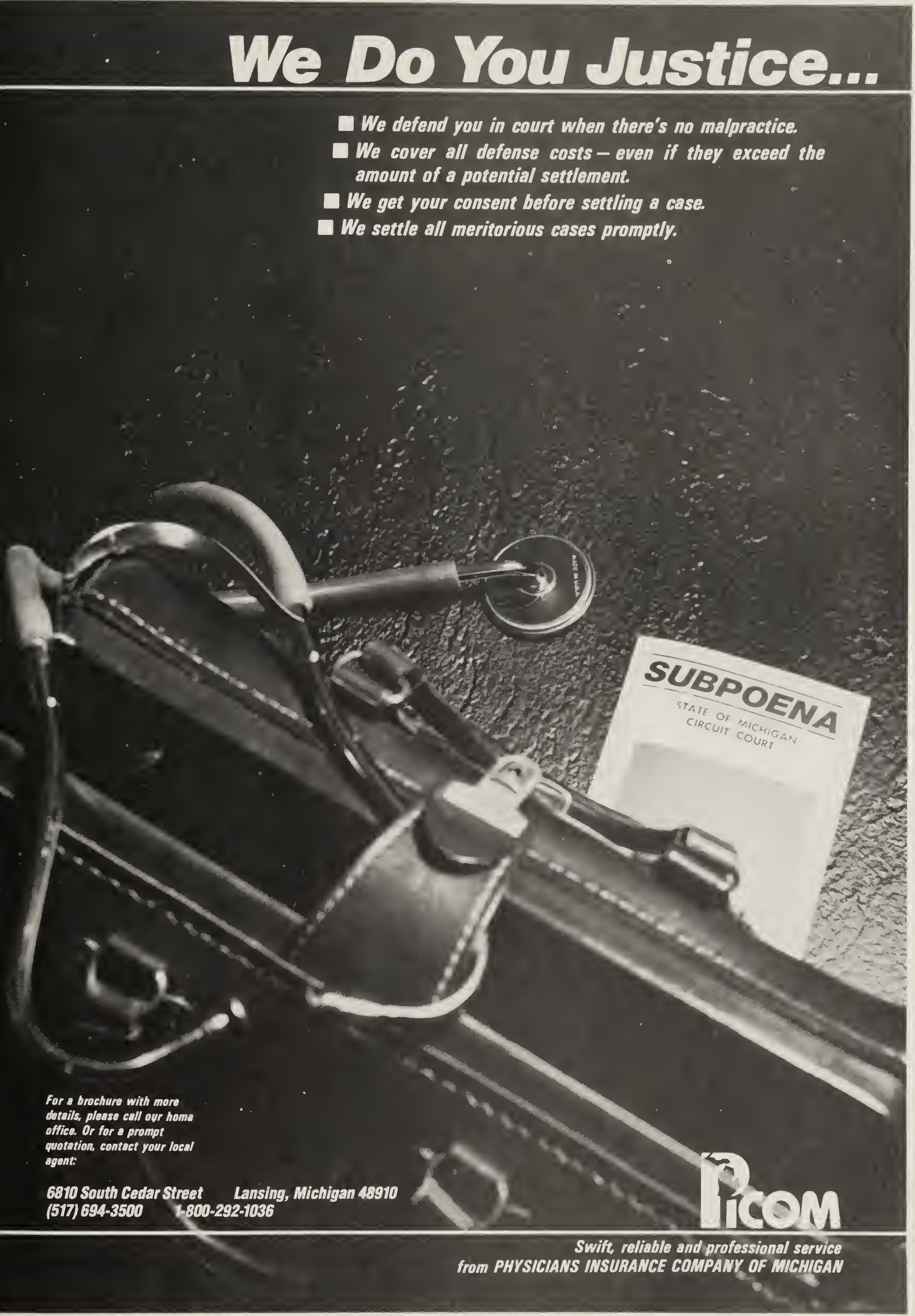
An Open Letter to Physicians with Physical Impairment

For the past two years, we have been involved in compiling a resource directory for physicians with physical impairment. The work is funded by a grant from the St. Paul-Ramsey Hospital Medical Education and Research Foundation. The purpose is to list physicians with various physical disabilities who are willing to provide information and referral services to physicians who incur the same disability and need specific information. Existing rehabilitation programs are simply not equipped to deal with the situation and 'Impaired Physician' services, except for the recently formed 'American Society of Handicapped Physicians' are directed almost exclusively to those physicians with mental illness and drug dependencies.

The biggest problem has been poor participation. It is currently estimated that 4% of all physicians are not in active practice because of a physically disabling condition, and that 25% of the physicians have the potential to be rehabilitated into the active practice of medicine. In real numbers this constitutes 1% of the licensed physicians in this country or 4,500 physicians. Our goal is to identify these physicians and encourage their participation. To date we have placed advertisements in over 100 major medical journals and have had response from less than 200 physicians. In retrospect, it appears this was due to the use of inappropriate terminology in the ads. Physical disability does not imply inability. Our use of the term "handicapped physician" was inappropriate since the majority of physically disabled physicians are not handicapped in their practice of medicine. We apologize for the inappropriate terminology and again ask that all physicians, active or inactive, with any type of physical disability contact Dr. Zondlo, St. Paul-Ramsey Hospital Medical and Educational Research Foundation, 640 Jackson St., St. Paul, MN 55101. The directory will be completed in 6-8 months and at that time it will be sent to only those physicians who are listed therein. Upon receipt of your initial response, information forms will be mailed. All correspondence is confidential.

All physicians with physical disability, no matter how small, are encouraged to respond. Information from a doctor with even a minor disability may be of value to another doctor with multiple disabilities. The cornerstone of this project is your participation.

Frank Zondlo, M.D.



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LETTERS

The following letter to nationally syndicated columnist James Kilpatrick is printed with permission of its author.

I have read your column in our local paper, the *Grand Rapids Press*, quite diligently for many years, and generally I am quite in accord with, and sympathetic to your views.

On December 26, 1982 however, your editorial about physician and American Medical Association lobbying against Federal Trade Commission control over the professions was totally untrue and unfounded. Several months ago, columnist Jack Anderson beat you to the punch with another editorial highly critical of the medical profession, and again totally untrue and unfounded.

I will state my case very briefly and through a very honest point.

I graduated from the University of Michigan Medical School in 1948 and began practice in the specialty of internal medicine in 1954 after two years of military service. In all that time, I have never had one communication or one word of advice from any physician or any city, state, county, or national medical society such as the AMA about the fee that I charge a patient. A physician's fee is entirely up to that physician. I can assure you that medical societies do *not* lobby for fixing their fees.

In that same span of time since 1954 however, I have had literally hundreds of pounds of mail from various medical associations and societies in the form of medical journals and publications which are published with the only goal of raising our professional abilities and acuity. You may remember that physicians have always been the most diligent about continuing medical education, and indeed founded continuing medical education before there was any such requirement from any government agency.

I am sure that your conservative bent should convince you that professional associations are really better at policing themselves than (are) government regulations and your editorial recently not only is totally untrue, but fuels and perpetuates a falsehood besmirching our image.

Sincerely,
R.J. Chase, MD
Grand Rapids

MEDICO-LEGAL

What's the hurry?

By A. Stewart Kerr
Detroit

A substantial but undetermined number of medical malpractice lawsuits are not commenced until after the patient has been dunned by a collection agency or a lawsuit filed for the unpaid fees.

As Michigan physicians know, the Michigan statute of limitations on malpractice actions is two years and can extend even longer. Ordinary prudence would suggest that physicians wait 24 months after the last service rendered before starting a lawsuit for fees.

Whether to wait that period of time before utilizing a collection agency is a matter of judgment. If the creditor physician suspects that the dissatisfied patient would not have known of the alleged malpractice until a later time, the collection suit should be delayed longer than 24 months. However, the busy practitioner may not have time to evaluate each such episode; the two year delay will suffice in most instances.

Mr. Kerr is MSMS legal counsel and malpractice defense attorney.

MSMS Legal Counsel A. Stewart Kerr, Detroit, sends along the following summary of a recent ruling of interest to Michigan physicians. This summary first appeared in the "Trade Regulation Reports" weekly newsletter of the Commerce Clearing House, Inc., Chicago.

Payments to physicians for laboratory patronage could be illegal

Alleged payments to physicians and others to induce use of a company's medical laboratory services could constitute commercial bribery amounting to unlawful agreements to restrain and an attempt to monopolize the Chicago market for independent laboratory services, the federal district court in Chicago has ruled.

Although payments to customers in return for their patronage may constitute no more than a reduction in stated purchase price, payments to a customer's purchasing agent, without the customer's knowledge, could have an anticompetitive effect by skewing the customer's purchasing decisions, the court explained.

Such improper arrangements are possible with regard to medical laboratory services if patients or insurers pay stated charges for laboratory services and doctors accept payments in return for using a particular laboratory, in the court's view.

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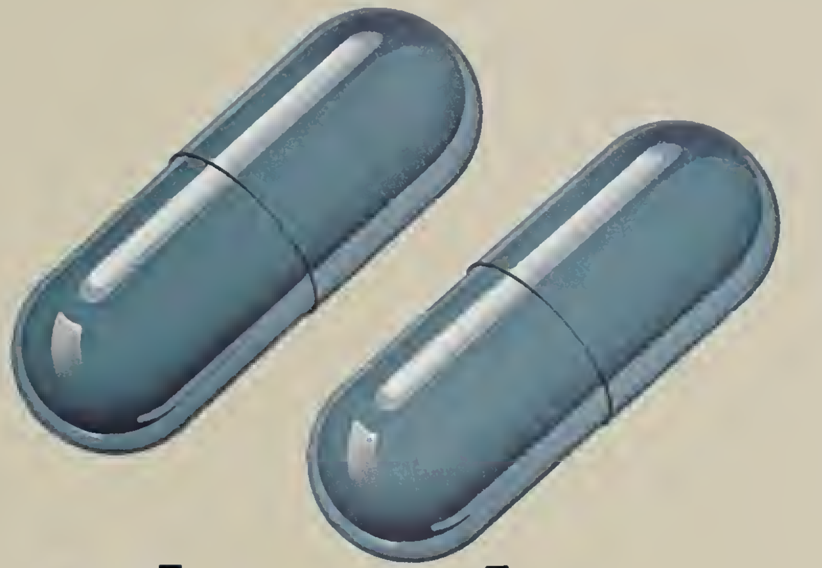

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VELOSEF® TABLETS 1 GRAM
Cephradine Tablets
VELOSEF® FOR ORAL SUSPENSION
Cephradine for Oral Suspension USP

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INDICATIONS AND USAGE: These preparations are indicated for the treatment of infections caused by susceptible strains of designated microorganisms as follows: Respiratory Tract Infections (e.g., tonsillitis, pharyngitis, and lobar pneumonia) due to *S. pneumoniae* (formerly *D. pneumoniae)* and group A beta-hemolytic streptococci [penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever; Velosef (Cephradine, Squibb) is generally effective in the eradication of streptococci from the nasopharynx; substantial data establishing the efficacy of Velosef in the subsequent prevention of rheumatic fever are not available at present]; Otitis Media due to group A beta-hemolytic streptococci, *H. influenzae,* staphylococci, and *S. pneumoniae;* Skin and Skin Structures Infections due to staphylococci and beta-hemolytic streptococci; Urinary Tract Infections, including prostatitis, due to *E. coli, P. mirabilis, Klebsiella* species, and enterococci *(S. faecalis).*

Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS: *Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use).* In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephradine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro.* Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis

produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

Diuretics (potent "loop diuretics," e.g., furosemide and ethacrynic acid) — Enhanced possibility for renal toxicity.

Probenecid — Increased and prolonged blood levels of cephalosporins, resulting in increased risk of nephrotoxicity.

Drug/Laboratory Test Interactions: After treatment with cephradine, a false-positive reaction for glucose in the urine may occur with Benedict's solution, Fehling's solution, or with Clinitest® tablets, but not with enzyme-based tests such as Clinistix® and Tes-Tape®. False-positive Coombs test results may occur in newborns whose mothers received a cephalosporin prior to delivery. Cephalosporins have been reported to cause false-positive reactions in tests for urinary proteins which use sulfosalicylic acid, false elevations of urinary 17-ketosteroid values, and prolonged prothrombin times.

Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy: Teratogenic Effects/Impairment of Fertility — Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

ADVERSE REACTIONS: Untoward reactions are limited essentially to G.I. disturbances and, on occasion, to hypersensitivity phenomena. The latter are more likely to occur in persons who have previously demonstrated hypersensitivity and those with a history of allergy, asthma, hay fever, or urticaria.

(continued on next page)

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(continued)

The following adverse reactions have been reported following use of cephradine: G.I. — Symptoms of pseudomembranous colitis can appear during antibiotic therapy; nausea and vomiting have been reported rarely. Skin and Hypersensitivity Reactions — mild urticaria or skin rash, pruritus, joint pains. Blood — mild transient eosinophilia, leukopenia and neutropenia. Liver — transient mild rise of SGOT, SGPT, and total bilirubin with no evidence of hepatocellular damage. Renal — transitory rises in BUN have been observed in some patients treated with cephalosporins; their frequency increases in patients over 50 years old. In adults for whom serum creatinine determinations were performed, the rise in BUN was not accompanied by a rise in serum creatinine. Others — dizziness, tightness in the chest, and candidal vaginitis.

DOSAGE: Adults — For respiratory tract infections (other than lobar pneumonia) and skin and skin structures infections: 250 mg q. 6 h or 500 mg q. 12 h. For lobar pneumonia: 500 mg q. 6 h or 1 g q. 12 h. For uncomplicated urinary tract infections: 500 mg q. 12 h; for more serious UTI, including prostatitis, 500 mg q. 6 h or 1 g q. 12 h. Severe or chronic infections may require larger doses (up to 1 g q. 6 h.).

Children over 9 months of age — 25 to 50 mg/kg/day in equally divided doses q. 6 or 12 h. For otitis media due to *H. influenzae:* 75 to 100 mg/kg/day in equally divided doses q. 6 or 12 h but not to exceed 4 g/day. Dosage for children should not exceed dosage recommended for adults. There are no adequate data available on efficacy of b.i.d. regimens in children under 9 months of age.

For full prescribing information, consult package insert.

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DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg., Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B Greenblatt, M.D ; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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MALPRACTICE CASE HISTORIES

By A. Stewart Kerr
Detroit

This article is the third in a series presenting the circumstances of actual medical malpractice cases taken from the files of MSMS Legal Counsel A. Stewart Kerr. It is presented in the interests of informing MSMS members of the consequences of poor record-keeping and other risky medical practices, and of illustrating what legal proceedings may do to the physician involved. MSMS members may submit questions by letter to A. Stewart Kerr, MSMS, 120 W. Saginaw St., East Lansing, 48823.

Mrs . Apotheosis v Doctor Noches

A defensible medical malpractice case can be considerably complicated by substandard charting.

On January 5 Mrs. Apotheosis had an ovarian cystectomy, performed by an OB-GYN. It was later found that somehow her ureter was injured. She was discharged without fever seven days later, which suggests that perhaps the ureter had infarcted out as a result of a ligature placed on it during the initial surgery. Mrs. Apotheosis developed fever, abdominal distention and fluids in the abdomen at home. On January 22 she was readmitted. The remainder of this saga involves the delay in diagnosing the urine leak.

No one did an intravenous pyelogram, perhaps because the presentation was so unusual that no one thought of it. A general surgeon, Doctor Noches, was consulted January 27, five days after readmission. He, too, did not suspect a urine leak and focused his attention on a possible bowel injury.

On January 29, the patient worsened and Doctor Noches, general surgeon, took the woman to surgery for an exploratory laparotomy. Finally, on January 30, an IVP was ordered by the OB-GYN.

Unfortunately, Doctor Noches did not dictate his operative note until much later; earlier dictation would have put him in better shape. He says that the OB-GYN was present at surgery but not scrubbed; that after discovering 3,000 cc of gelatinous material adherent to the bowel, he noticed a "uriniferous odor" and thus suspected a urine leak. He says he told this to the OB-GYN, recommended that Mrs. Apotheosis be referred to urology service for ureter repair and closed the patient, leaving drains in place to drain further urine. This approach is believed to be defensible.

Doctor Noches made a hand-written progress note after the surgery, describing a rare condition which was later ruled out by pathology; no mention of the urine leak. The urology service repaired the ureter and the patient was discharged on February 26.

Some seven months later, Mrs. Apotheosis sued (1) the OB–GYN: (2) Doctor Noches; and (3) the hospital. Doctor Noches went to examine the chart and was horrified to discover that his operative note had never been dictated. His operative note is dated seven days after the lawsuit was commenced and contains a *very* elaborate explanation of the search for the urine leak and contends that a uriniferous odor was present.

On deposition, the OB-GYN denied Doctor Noches' version and claimed that he (the OB-GYN) discovered the urine leak from an IVP that was taken after the surgery (the original IVP had been rescheduled a few days later than originally planned, to allow the patient to stabilize after surgery). The surgical resident testified by deposition to support Doctor Noches' version of events in the operating room.

As a medical matter, it would be more difficult for the OB-GYN to defend than for Doctor Noches to defend. But because of Doctor Noches' failure to dictate his operative note in timely fashion, his credibility is undermined; a jury may well not believe his version of events.

Kidley v Adumbral

Doctor Adumbral is a urologist of foreign extraction. He has difficulty speaking, spelling and writing English. Like many foreign doctors, Doctor Adumbral understands the added vulnerability he has in Court. He is, therefore, extremely cautious in his charting. This will help him in this pending case.

Mrs. Kidley, a 28-year-old woman with a non-functioning and atrophied left kidney, presented to Doctor Adumbral with a stenosis in the ureteropelvic junction of the right kidney. After diagnostic studies, Doctor Adumbral performed a right pyeloplasty (plastic surgical procedure on the kidney) to insert a stent into the right ureter to widen the opening. After appropriate reconstructive surgery at the site of the stenosis, a stent 10 inches long was placed in the right ureter, with one end in the renal pelvis (the point where the ureter joins the kidney) and the other end in the bladder. The stent was left in the appropriate period of time and then removed by Doctor Adumbral.

When Doctor Adumbral removed the stent, he suspected, but was not sure, that a small piece of it had broken off in Mrs. Kidley's renal pelvis. Even though it was possible that nothing was wrong, he elaborately explained to Mrs. Kidley that this may have happened and that this could require additional hospitalization and surgery. He wrote all this out in the progress notes and had Mrs. Kidley sign her name on the progress note.

Doctor Adumbral had, in fact, broken off a small piece of the stent. It took two years for enough calcification to grow around the tiny fragment to show on x-ray. It was removed surgically at University of Michigan. Doctor Adumbral was sued by Mrs. Kidley. The lawsuit still has some value but is not nearly as dangerous as it would have been if Doctor Adumbral had not taken great care that his explanations to the patient were documented.

Comment

Suppose that Mrs. Kidley had started her lawsuit after the statute of limitations had run? If she had waited longer and tried to claim fraudulent concealment of her claim by Doctor Adumbral, Doctor Adumbral's action of having her sign the progress note in the hospital would prove invaluable to his defense.

Mr. Kerr is MSMS legal counsel.

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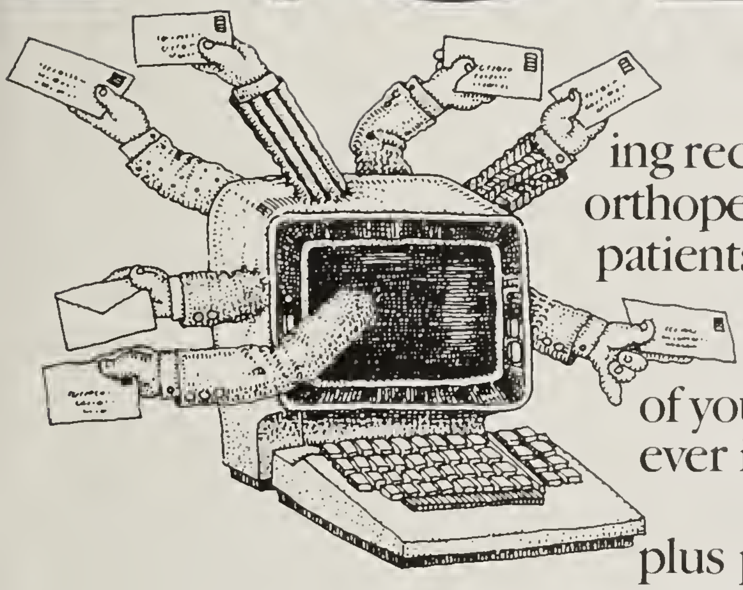

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New MSMS legislation designed to alleviate malpractice situation

Michigan State Medical Society is proposing legislation which will clarify and circumscribe procedures for determining physician liability in claims of professional malpractice. Adoption of these proposals into state law will:

- Permit in indemnity hearings consideration of collateral source payments received by plaintiff as result of incident on which claim is based;
- Assure qualifications of expert witnesses;
- Establish degree of fault for which a defendant can be held liable in cases with multiple defendants;
- Place reasonable limits on awards to compensate for pain, suffering, inconvenience, physical impairment and other non-economic losses;
- Permit payment of certain damages in whole or in part by periodic payments rather than lump-sum.

Cost Impact

Passage of these proposals will tend to restrain the rise in that portion of health care costs attributable to high premiums for professional liability insurance.

Expenditures for health care in Michigan, reflecting national trends, has increased more than 200 percent during the last 10 years — 15 percent during 1981.

The average annual cost for each American is now more than $1,200.

Expenditures for hospital care quadrupled during the 1970's and expenditures for physicians' services tripled. Health care expenditures continue to grow at a rapid rate. In 1981, while the consumer price index climbed 8.9 percent, medical costs went up 15.1 percent.

During these same years the cost of liability insurance for physicians skyrocketed. Annual premiums for comparable coverage in non-surgical practice increased 1,000 percent. Maximum premiums for heart surgeons now exceed $20,000.

Concern about medical costs is increasing among physicians and the general public alike, according to a survey made by American Medical Association. The survey found that physicians' concerns over costs are up sharply, and the issues relating to malpractice and the cost of professional liability insurance are major concerns.

The inflation rate in health care costs is "out of control" reports the Health Insurance Association of America. Considering the situation critical, HIAA has called for:

- A presidential commission to make recommendations to Congress;
- Legislation to allow insurers to negotiate with hospitals to cut costs;
- Establishment of state payment systems "to predetermine approved hospital revenues and encourage cost containment."

High Priority

Michigan State Medical Society through its Task Force on Medical Care Costs and special committees have given high priority to methods of reducing costs. Michigan physicians are, in fact, leading the way in efforts to moderate medical costs without jeopardizing the quality of patient care or reducing ready access to services.

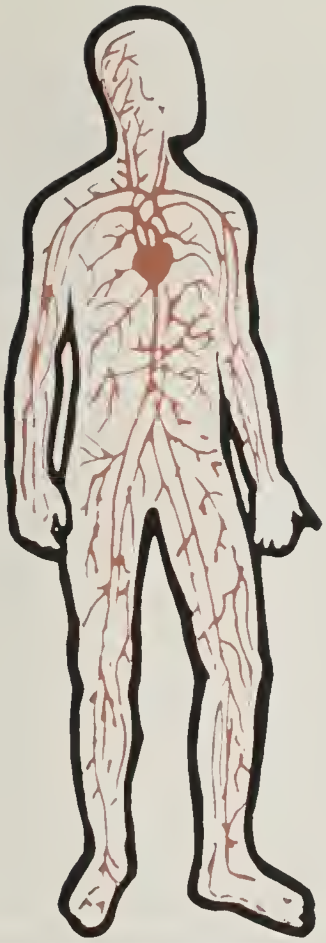
MSMS and medical specialty associations, through Continuing Education and Risk Management programs, are not only renewing and expanding professional skills, they are learning how to operate their practices more efficiently through better management.

There are many factors affecting cost-for-service over which individual physicians and the medical profession have no direct control, e.g. economic inflation and professional liability insurance premiums. Some elements of cost can be brought under control only through legislation.

These concerns and these initiatives are reflected in Michigan State Medical Society programs and in the legislative proposals presented in this document.

Following is the text of the MSMS proposed legislation to help alleviate the medical malpractice situation in Michigan. Improvements in this area ultimately will make it easier for physicians to help hold down health care costs.

Continued on page 152



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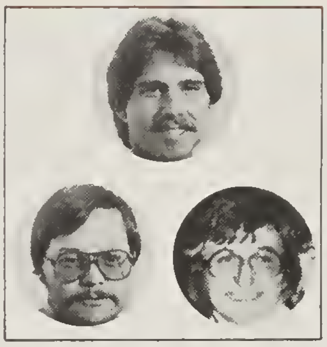

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Following is the subject, rationale and proposed language of new malpractice legislation MSMS is seeking to have written. The goal is to alleviate current medical malpractice problems. *Michigan Medicine* and *Medigram* will keep MSMS members posted on the progress of this proposed legislation.

Elimination of collateral source rule

The concern

The collateral source rule is a rule of evidence which prohibits the introduction into evidence at a trial of any indication that a patient has been compensated or reimbursed for his injury from any source other than the defendnant, such as private health insurance or workers' compensation.

Traditionally, tort law has sanctioned a partial or total double recovery by an injured plaintiff, refusing to reduce a liability judgment by the amounts the plaintiff received from collateral insurers.

Michigan State Medical Society does not agree that a plaintiff should retain collateral payments and receive full compensation from the defendant in a medical malpractice action. The basic aim of the tort law is to make the plaintiff whole, not to over-compensate him. The extent to which the defendant must respond in damages is more appropriately measured by the harm endured by the plaintiff than by the degree of the defendant's fault.

The repeal of the collateral source rule would have a measurable impact on premium costs according to a study reported by American Bar Association's Fund for Public Education. The report stated that in a typical state which had broadly repealed the collateral source rule it would be reasonable to suggest that "malpractice award dollars would be about 20 percent less than at present."

A recent study by the Rand Corporation's Institute for Civil Justice of 6,000 medical malpractice claims filed during the mid-1970s concluded that relaxing the ban on evidence of collateral sources of compensation for injuries appeared to reduce trial awards by 18 percent.

Proposed legislation

This legislation would require disclosure of all compensation or payments received by the plaintiff from collateral sources as a result of a professional liability incident.

Limitation of expert testimony

The concern

Testimony of an "expert witness" usually is required to establish a cause of action for malpractice. The Michigan Court of Appeals holds that expert testimony is an absolute prerequisite to the patient's right to recover for the alleged malpractice of a physician or a hospital.

Expert testimony is necessary to establish both the appropriate standard of care and the physician-defendant's violation of that standard. The expert testimony requirement is predicated upon the belief that in cases involving professional services, ordinary laypersons are not equipped by knowledge and experience to judge the skill and competence of that service and to determine whether it meets the standard of professional practice in the community or, in the case of specialists, with the standard of the specialty.

As a general rule, the standard for professional care is determined by professionals practicing in the same community or similar communities. Medical witnesses may testify to the standards of care in a particular locality if they are familiar with the standard in that or similar areas. The test is not whether the expert witness ever practiced in the same or similar areas as the defendant physician.

The Michigan Court of Appeals holds that even though an expert witness never treated a patient in the local area and is generally unfamiliar with medical services available in the area, that witness is sufficiently qualified to testify as an expert if the background of the medical witness is acceptable and the nature of the medical conditions involved is familiar to that witness.

Physicians may testify in medical malpractice actions as to the standard of care applicable to physicians belonging to another school of practice so long as the physician serving as an expert witness is familiar with applicable standards of the other physician's school.

Medical physicians have been permitted to testify as to the standard of care of osteopathic physicians in Michigan. Specialists may testify in malpractice actions involving general practitioners providing the specialists have knowledge of the standards required of general practitioners.

If the court determines specialized knowledge is required to assist in understanding the evidence, or to establish a fact in issue, the witness qualified as an expert my testify thereto.

As a general rule, any licensed physician is considered to be a medical expert. Only the fact of licensure need be shown in order to establish the witness' right to give opinion testimony.

Physicians, as other professionals, including attorneys, are traditionally reluctant to take public positions regarding the competence, or incompetence of their peers. However as physicians have developed an increased understanding of the judicial process, they have become more willing to stand by their injured patients, legally as well as medically, and to recognize that the process presents opportunities to facilitate quality medical care.

Physicians also realize, especially with the advent of companies specializing in the provision of medical experts, that their willingness to testify in court provides a more legitimate source of expert testimony, to the ultimate benefit of their profession.

Physicians generally, and the official policy of the Michigan State Medical Society, support legislation which would limit the use of medical expert witnesses to those who are in

Continued on page 154

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fact acquainted with the relevant standards of practice in the community of the claimed malpractice incident, or with the standards of a comparable Michigan community; and are physicians who spend most of their time in clinical practice in the specialty of the defendant physician.

Proposed legislation

The proposed legislation placing limits on the competency of expert testimony is designed to implement the legislation on the burden of proof in malpractice cases set forth in MCLA 600.2912a. It sets forth the professional competency requirements for expert witnesses in cases against non-specialists and specialists. The proposed legislation states in part:

No person shall be deemed competent to give expert testimony on the liability issues as defined in MCLA 600.2912A(a), (b), unless:

1. In the case of a claim against a non-specialist:

(a) Such person holds a license to practice medicine and surgery or osteopathic medicine and surgery granted by the appropriate licensing board of the State of Michigan; and

(b) Such person devotes at least three-fourths of his or her occupational and professional time to the active clinical practice of medicine and surgery, or osteopathic medicine and surgery, and/or to its instruction in an accredited medical or osteopathic school.

2. In the case of a claim against a specialist:

(a) Such person holds a current license to practice medicine and surgery or osteopathic medicine and surgery granted by the appropriate licensing board of any state; and

(b) Such person was and is board certified by the appropriate certifying body in the same specialty as the accused specialist, both at the time of the occurrence of the alleged claim and at the time of testifying; and

(c) Such person devotes at least three-fourths of his or her occupational and professional time to the active clinical practice of medicine and surgery in the same specialty as the accused specialist, or osteopathic medicine and surgery in the same specialty as the accused specialist, and/or to its instruction in an accredited medical or osteopathic school in the same field as the accused specialist.

Abolition of Joint Liability

The concern

The rule of joint and several liability is based on the assumption that multiple defendants are members of a group who have engaged in concerted action, an assumption that is inappropriate in a procedure in which defendants who have acted in concert can be sued in the same action as defendants who have no prior connection with others.

Under this rule each defendant held in any degree liable for compensation of an injury is required to pay the entire amount of judgment to the plaintiff upon demand. When more than one party is sued over the same incident and a judgment is awarded, if one party is unable to pay, the other party is liable for the total judgment. A defendant who may have been only five percent responsible for the plaintiff's injuries may be required to pay the full amount of the judgment.

The Michigan State Medical Society holds that it is unfair to burden a defendant with responsibility for payment of the full amount of an award in which he was found to have a small percentage of liability.

Proposed legislation

Any judgment against two or more parties based upon medical malpractice and/or lack of informed consent shall be deemed satisfied as to a party upon payment of the amount attributable to that party's relative degree of fault.

Limitation of non-economic damage

The concern

It is the right of an injured party in a malpractice judgment to recover the full amount of economic loss, i.e., the loss of earnings and earning capacity, and the cost of medical and hospital care incurred in the past and reasonably expected to be incurred in the future.

However, a substantial portion of verdicts being returned in medical malpractice is not for economic loss, but rather for intangible and ambiguous items for damage such as loss of capacity for enjoyment of life or inability to lead a normal life. These claims of loss are not amenable to accurate or even approximate monetary assessment — translation into dollar equivalence is an arbitrary process.

Members of Michigan State Medical Society are confident that reasonable limits on pain and suffering awards would lead to a significant reduction in liability payments.

Proposed legislation

Recommended legislation includes the following provisions:

(a) In any action for injury against a health care provider based on malpractice or lack of informed consent, the injured plaintiff shall be entitled to recover noneconomic losses to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damage.

(b) In no action shall the amount of damages for noneconomic losses exceed $500,000.00.

(c) For purposes of this section, "health care provider" means a person, partnership or corporation lawfully engaged in the practice of medicine, surgery, dentistry, podiatry, optometry, chiropractic or nursing; or a person, partnership or corporation lawfully engaged in the operation of a hospital, clinic, health maintenance organization, or sanitarium. "Health care provider" includes the legal representatives of a health care provider.

Periodic payments of future damages

The concern

One reason malpractice insurance premiums are unnecessarily high is the practice of awarding claims on a lump sum payment basis which often leads to overpayments not intended by the judge or jury.

For example, an injured patient might be awarded millions of dollars for future treatment on assumption that the life expectancy of the person is 30 additional years. If the patient dies in ten years from causes unrelated to his compensated injury, the award is not used for its intended purpose.

The structured payout offers protection to the injured person by preventing injudicious use of lump sum settlements by guardians or persons ill-equipped to handle large sums of money. The funds may be exhausted before the needs of the injured person have been met.

Michigan State Medical Society supports the concept of award payments over a period of time.

Proposed legislation

Recommended legislation includes the following provisions:

(a) In any verdict against a health care provider based on malpractice or lack of informed consent, the trial court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the verdict equals or exceeds Fifty Thousand and 00/100 ($50,000.00) Dollars in future damages. In entering a judgment ordering the payment of future damages by periodic payments, the court shall make a specific finding as to the dollar amount of periodic payments which will compensate the judgment creditor for such future damages. As a condition to authorizing periodic payments of future damages, the court shall require the judgment debtor who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the judgment debtor.

(b)(1) The judgment ordering the payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments and the number of payments or the period of time over which payments shall be made. Such payments shall only be subject to modification in the event of the death of the judgment creditor.

(2) In the event that the court finds that the judgment debtor has exhibited a continuing pattern of failing to make the payments, as specified in paragraph (1), the court shall find the judgment debtor in contempt of court and, in addition to the required periodic payments, shall order the judgment debtor to pay the judgment creditor all damages caused by the failure to make such periodic payments, including court costs and reasonable attorney fees.

(c) Money damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the judgment creditor, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately prior to his death. In such cases the court may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this subdivision.

(d) Following the expiration of all obligations specified in the periodic payment judgment, any obligation of the judgment debtor to make further payments shall cease and any security given, pursuant to subsection (a), shall revert to the judgment debtor.

(e) As used in this section:

(1) "Future damages" means compensation for losses not yet incurred including, but not limited to, damages for future medical treatment, care or custody, loss of future earnings, loss of bodily function, or future pain and suffering of the judgment creditor.

(2) "Periodic payment" means the payment of money or delivery of other property to the judgment creditor at regular intervals.

(3) "Health care provider" means a person, partnership, or corporation lawfully engaged in the practice of medicine, surgery, dentistry, podiatry, optometry, chiropractic or nursing, or a person, partnership or corporation lawfully engaged in the operation of a hospital, clinic, health maintenance organization or sanitarium. "Health care provider" includes the legal representatives of a health care provider.

(f) It is the intent of the legislature in enacting this statute to authorize the entry of judgments in malpractice or lack of informed consent actions against health care providers which provide for the payment of future damages through periodic payments rather than lump-sum payments. By authorizing periodic payment judgments, it is the further intent of the legislature that the courts will utilize such judgments to provide compensation sufficient to meet the needs of an injured plaintiff and those persons who are dependent on the plaintiff for whatever period is necessary while eliminating the potential windfall from a lump-sum recovery which was intended to provide for the care of an injured plaintiff over an extended period who then dies shortly after the judgment is paid, leaving the balance of the judgment award to persons and purposes for which it was not intended. It is also the intent of the legislature that all elements of the periodic payment program be specified with certainty in the judgment ordering such payments and that the judgment not be subject to modification at some future time which might alter the specifications of the original judgment.

Tips from the Pros.

The Slant on Sidehill Shots

When you're facing uphill, with the ball resting above your feet, you should stand a bit farther from it than normal. You should also make a "flatter" swing than normal, more like a merry-go-round than a ferris wheel.

When facing downhill, with the ball below your feet, stand closer to it and swing more "upright", like a ferris wheel instead of a merry-go-round.

In either instance, it's always best to take a couple of practice swings. It's also wise to swing with less effort than normal in order to retain your balance.

The Topspin Forehand Swing

There is no wrong time to hit a topspin. If you can hit it regularly—use it. All the pros do.

The key to the topspin forehand is your ability to get under the ball and swing up quickly. The forward swing of the flat foreward drive begins as if you were sweeping off a table top with your arm. Only after you have made contact do you begin to raise your racket and finish high. And as you finish, you swing out to the court.

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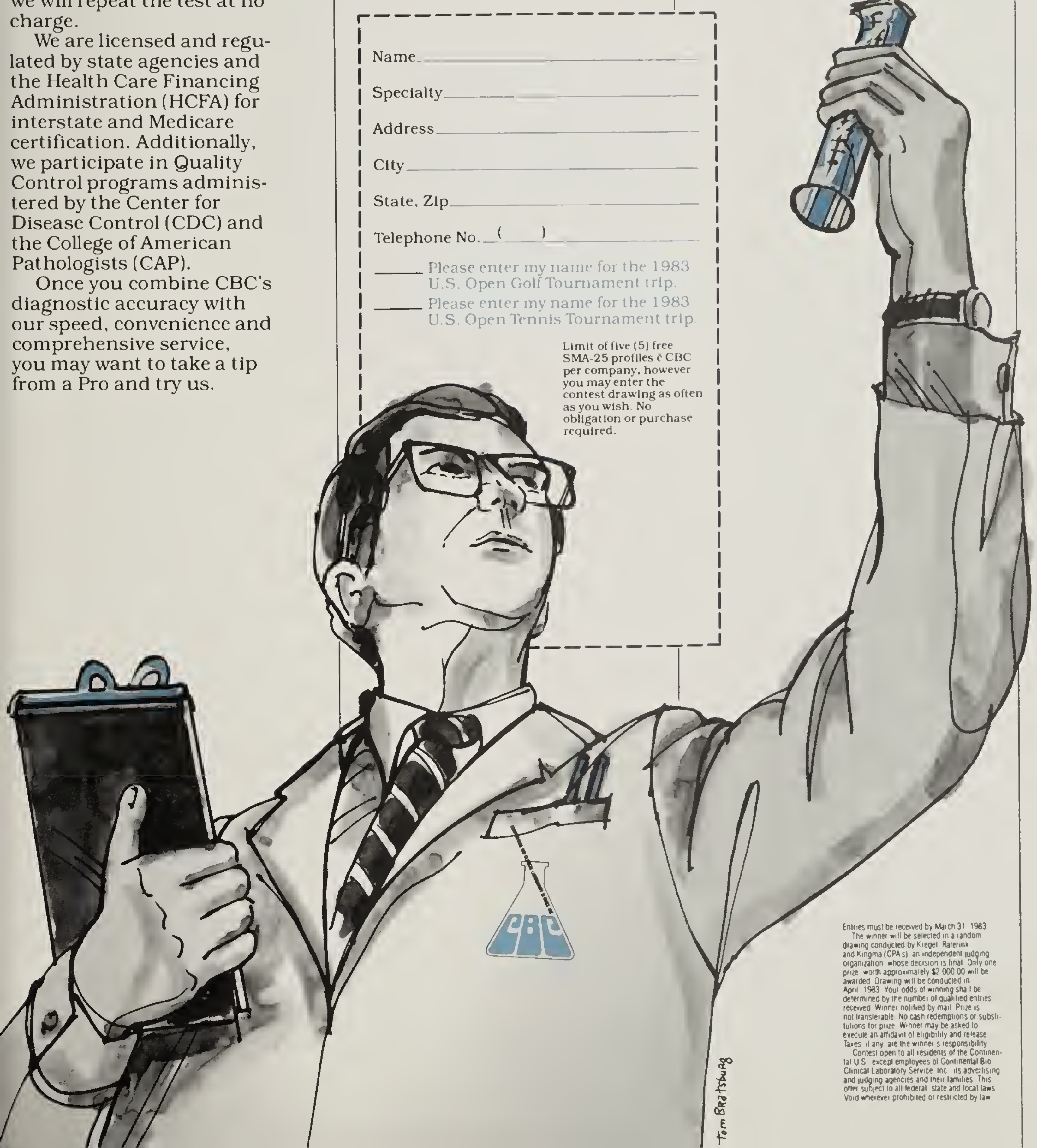

Entries must be received by March 31, 1983.

The winner will be selected in a random drawing conducted by Kregel, Raterink and Kingma (CPA's), an independent judging organization, whose decision is final. Only one prize, worth approximately $2,000.00 will be awarded. Drawing will be conducted in April, 1983. Your odds of winning shall be determined by the number of qualified entries received. Winner notified by mail. Prize is not transferable. No cash redemptions or substitutions for prize. Winner may be asked to execute an affidavit of eligibility and release. Taxes, if any, are the winner's responsibility.

Contest open to all residents of the Continental U.S., except employees of Continental Bio-Clinical Laboratory Service, Inc., its advertising and judging agencies and their families. This offer subject to all federal, state and local laws. Void wherever prohibited or restricted by law.

Board of Medicine disciplinary actions

The following actions of the Michigan Board of Medicine were taken following investigative and appropriate action and are summarized below by MSMS legal counsel from official memoranda to MSMS. Any subsequent actions of the board will be printed in future issues.

• **Ronald Carl Zajac, MD**
11459 McDougall
Hamtramck, 48212
Date, action taken
April 13, 1982
Final order — license reinstated, limited probationary basis, for three years under conditions: no license for controlled substances for two years; solo practice forbidden for three years; psychotherapeutic help for one year, with quarterly reports to the Board; quarterly reporting to the Board for three years, periodic year-end blood analyses re controlled substances; books and records must be kept by CPA; pending criminal charges not to be the basis for further sanctions by the Board; etc.
Alleged violation:
Not specified

• **Weldon J. Cooke, MD**
Southwestern Medical Center
2 Hospital Drive
Berrien Center 49102
Date, action taken
August 11, 1982
Final order, by agreement, one year suspension of license; 50 hours of supplementary CME (in addition to statutory requirement); three years probation, with a percentage of surgical cases submitted for Board review.
Alleged violation:
Surgical errors

• **Mahfouz El-Tawil, MD**
Central Michigan Community Hospital
Mt. Pleasant 48858
Date, action taken
Aug. 11, 1982
Formal reprimand; license restricted for one year, limiting practice to anesthesiology, with limitations on prescribing and ordering drugs.
Alleged violations:
Inadequate diagnosis; prolonged prescription of Talwin

• **Larry G. Goss, MD**
417 Monroe
Bangor, MI 49013
Date, action taken
Aug. 11, 1982
Final order: Insufficient evidence of violation of law; reprimand; Probation for one year.
Alleged violation:
Prolonged prescriptions for Dilaudid

• **John D. Kucera, MD**
4452 N. Spieder Lake Road
Traverse City 49684
Date, action taken
August 11, 1982
Disposition: Insufficient evidence of legal violation; reprimand.
Alleged violations:
Prescription and dispensing of Dextroamphetamines and failure to maintain detailed records.

• **David B. Witte, MD**
403 Phoenix
South Haven 49090
Date, action taken
August 11, 1982
Disposition: Reprimand; one-year probation.
Alleged violation:
Failure to follow minimal standards and failure to exercise due care in prescriptions of Dilaudid for a drug dependency.

• **John H. Hoffmann, MD**
151 North Street
Battle Creek 49017
Date, action taken
Oct. 13,1982
Consent order: One-year probation, submit to random testing of body fluids quarterly; visit neurologist every 90 days; reporting requirements for probation period, quarterly.
Alleged violation:
Controlled substances.

• **Stanley M. Lynk, MD**
4589 Lippincott Road
Lapeer 48446
Date, action taken
Nov. 11, 1982
Final order: License suspended three years; physical and mental exams a condition precedent to any subsequent reinstatement hearing; must meet reinstatement criteria.
Alleged violations:
Failure to conduct appropriate examination of patient; inappropriate prescriptions for Percodan and Valium; improper records; etc.

• **Edward A. Hoffman, MD**
10125 Tireman
Dearborn 48126
Date, action taken
Dec. 15, 1982
Consent order; Result, per consent order: reprimand; permanent surrender of controlled substances license.
Alleged violations:
Nature of violation not stated

• **Robert P. Rogers, MD**
7845 Middle Belt Road
Romulus 48174
Date, action taken
Dec. 15, 1982
Consent order: Reprimand; one-year probation, with no orthopedic surgery except under specified supervision; supervisor to file quarterly reports; 50 hours of CME required in orthopedic surgery in addition to license renewal requirements.
Alleged violation:
Not known

• **Jeffrey P. Bolduan, MD**
101 Marilyn Ave.
Goshen, Indiana 46526
Date, action taken
Dec. 15, 1982
Consent order: Physician has moved to another state and has agreed to retire permanently from any practice of medicine in Michigan. Permanent surrender of license.
Alleged violation:
Not specified

• **Fred M. Jameson, MD**
833 Lake Drive SE
Grand Rapids 49506
Date, action taken
Jan. 4, 1983
Consent order: Reprimand; one-year probation, requiring board meeting every three months to discuss current prescribing of controlled substances; demonstrated knowledge of requirements for prescribing amphetamines; maintenance of separate lists of controlled substances for outpatients, etc.
Alleged violation:
Acted below minimal standards of acceptable practice, failed to exercise due care and prescribed for other than lawful diagnostic or therapeutic purposes.

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*1979. The National Underwriter Company

Board of Medicine repeats warning on over-prescribing controlled substances

Michigan Medicine repeats this announcement, which appeared in 1981 editions of the magazine at the request of the Board of Medicine. The board members believe the situation is serious enough that it warrants another reminder.

The Michigan Board of Medicine, Department of Licensing and Regulation, has become increasingly concerned about the number of physicians who are prescribing controlled substances to individuals for purposes of maintaining that person's drug dependency. The Michigan Board of Medicine wishes to advise that physicians who are participating in this activity in an inappropriate manner are doing so at risk to their professional and controlled substance licenses.

Administrative Rule 63, promulgated under authority of the Public Health Code, Section 7201, being R 338.3163 of the Controlled Substances chapter states in paragraph (1)(a):

"A prescriber licensed in accordance with federal and state law to conduct the drug treatment of a drug dependent person *in a program* may prescribe a controlled substance for the purpose of legitimate treatment of the drug dependent person." (Emphasis added)

Also, Administrative Rule 70, being R 338.3170 states in paragraph (2):

"A prescriber may dispense or administer, or both, in the course of his or her professional practice a controlled substance listed in schedules 2, 3, 4, and 5 directly to the drug dependent person for the purpose of continuing his or her dependence *in a drug treatment and rehabilitation program.*" (Emphasis added)

Physicians should also be aware that many persons go to several physicians and several pharmacies to obtain controlled substances. A physician should inquire whether this is occurring by contacting pharmacies and other physicians.

The physician should be circumspect in prescribing so as not to jeopardize the professional or controlled substance license.

Should you have questions in this regard, please address them to the office of the Michigan Board of Medicine.

Carl E. Cross, Jr.
Licensing Executive
Michigan Board of Medicine

MEDICAL EXAMINER

Oakland County, Michigan is seeking candidates for the position of Medical Examiner.

Candidates must be certified by the ABP in Forensic Pathology and should have leadership experience in Medicolegal investigations and forensic sciences. Salary is negotiable.

The Medical Examiners' office is fully staffed, including toxicology and histology services and housed in a modern, well equipped facility at the Oakland County Service Center.

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L.A. Volberding
Director-Institutional and
Human Services Department
Oakland County
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Federally-supported peer review in flux as regulations due, funding uncertain

By Deborah Zannoth
East Lansing

The future of federal medical peer review structures is uncertain, at best. New federal statutes call for reorganizing the old PSRO system; but the administration is calling for repeal of the new system, even before it is put into place.

The following article brings Michigan physicians up to date on the latest developments.

The Tax Equity and Fiscal Responsibility Act was passed by Congress on August 19, 1982. Under TEFRA the existing Professional Standards Review Organizations (PSROs) are to be repealed and replaced with the Utilization and Quality Control Peer Review Organization (PRO) Program.

PSROs were enacted in October 1972 to "promote the effective, efficient and economical delivery of health care services of proper quality for which payment may be made" under the Medicare, Medicaid and Maternal and Child Health Care Programs.

Ms. Zannoth is assistant to the MSMS Bureau of Economics.

The PSRO law authorized the secretary of Health, Education and Welfare to establish geographic areas in which PSROs could be designated and to enter into agreements with qualified organizations.

PSROs were responsible for determining if the services provided in an institutional setting were medically necessary, met professionally recognized standards of care and were furnished in the most economical setting.

To date, the effectiveness of the PSRO program has been the subject of considerable dispute. In 1981, based on evaluation of the PSRO program by the Congressional Budget Office, the administration proposed to phase out federal funding of PSROs.

However, after several congressional hearings and the introduction of a number of bills to revamp the program, a compromise was reached which has resulted in the repeal of the PSROs and enactment of the Utilization and Quality Control Peer Review (PRO) Program.

The Peer Review Improvement Act of 1982 authorizes the secretary of Health and Human Services to contract with PROs for the purpose of promoting the effective, efficient and economical delivery of health care services and of promoting the quality of services under the Medicare program.

The new law is quite similar to the PSRO law. However, there have been some significant changes.

Geography

Existing PSRO areas are to continue until the secretary consolidates them and enters into a contract with a PRO for their review area. Each state generally will be considered a geographic area for a PRO. States with fewer than 180,000 annual Medicare/Medicaid hospital admissions must be a single statewide PRO. Local or regional areas can be established which have over 60,000 total hospital admissions (includes private pay).

Definition

A PRO is an entity (non-profit or for-profit) composed of a substantial number of physicians practicing in the area, or which has available the services of a sufficient number of such physicians to assure adequate peer review. During the first 12-month period in which contract applications are considered, third party payors or hospital affiliated organizations will not be allowed to contract with the secretary to conduct reviews.

The PRO is to review the pattern of quality of care in an area of medical practice where actual performance is measured against objective criteria which define acceptable and adequate practice. PROs are specifically authorized by statute to determine the types and kinds of cases they will review and thus will be able to focus their review on problem areas.

Continued on page 162

Contracts

The secretary will enter into a two-year, renewable contract with a qualified PRO for each designated geographic area.

Payment will be specified in the contract. The contractor may subcontract for performance of all or some of the functions.

The new law requires contracts to include negotiated objectives against which the organization's (PRO) performance will be judged. Specifications will be negotiated to determine regional norms. These norms will be based on national standards of care and must recognize different but acceptable modes of treatment.

The contract can be terminated or not renewed on 90 days' notice by either party; however, the PRO will have an opportunity to submit data on its performance before being cancelled by the secretary.

Confidentiality

The PRO law clarifies that for purposes of the Freedom of Information Act, a PRO is not a federal agency.

Councils

The PRO law eliminates the Statewide and National Professional Standards Review Councils.

Contracting

The PRO law requires PROs to "make available" their facilities and resources for contracting with both private and public payors in its area for review of medical services.

The PRO program will be administered by the Health Standards and Quality Bureau (HSQB) of the Health Care Financing Administration under the direction of Philip Nathanson.

The Notice of Proposed Rulemaking (NPRM) for area designations and contract criteria is currently under development. The phasing-in of PROs is scheduled to begin on October 1, 1983. However, MSMS has learned that in the administration's budget for FY 1984, no funds have been allocated for PROs. The administration actually is seeking a repeal of the PRO statute.

BRIEF SUMMARY
PROCARDIA® CAPSULES For Oral Use
(nifedipine)

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria: 1) classical pattern of angina at rest accompanied by ST segment elevation, 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm. In those patients who have had angiography, the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied. PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e.g., where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm, or when angina is refractory to nitrates and/or adequate doses of beta blockers.

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or organic nitrates or who cannot tolerate those agents.

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete.

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment, especially in patients with compromised left ventricular function or cardiac conduction abnormalities. When introducing such concomitant therapy, care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs. (See Warnings.)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCARDIA.

WARNINGS: Excessive Hypotension: Although in most patients, the hypotensive effect of PROCARDIA is modest and well tolerated, occasional patients have had excessive and poorly tolerated hypotension. These responses have usually occurred during initial titration or at the time of subsequent upward dosage adjustment, and may be more likely in patients on concomitant beta blockers

Severe hypotension and/or increased fluid volume requirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker, but the possibility that it may occur with PROCARDIA alone, with low doses of fentanyl, in other surgical procedures, or with other narcotic analgesics cannot be ruled out.

Increased Angina: Occasional patients have developed well documented increased frequency, duration or severity of angina on starting PROCARDIA or at the time of dosage increases. The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate, or from increased demand resulting from increased heart rate alone

Beta Blocker Withdrawal: Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina, probably related to increased sensitivity to catecholamines Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release. There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation. It is important to taper beta blockers if possible, rather than stopping them abruptly before beginning PROCARDIA

Congestive Heart Failure: Rarely, patients, usually receiving a beta blocker, have developed heart failure after beginning PROCARDIA. Patients with tight aortic stenosis may be at greater risk for such an event

PRECAUTIONS: General: Hypotension: Because PROCARDIA decreases peripheral vascular resistance, careful monitoring of blood pressure during the initial administration and titration of PROCARDIA is suggested Close observation is especially recommended for patients already taking medications that are known to lower blood pressure. (See Warnings.)

Peripheral edema: Mild to moderate peripheral edema, typically associated with arterial vasodilation and not due to left ventricular dysfunction, occurs in about one in ten patients treated with PROCARDIA This edema occurs primarily in the lower extremities and usually responds to diuretic therapy. With patients whose angina is complicated by congestive heart failure, care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction.

Drug Interactions: Beta-adrenergic blocking agents: (See Indications and Warnings.) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PROCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure, severe hypotension or exacerbation of angina.

Long-acting nitrates: PROCARDIA may be safely co-administered with nitrates, but there have been no controlled studies to evaluate the antianginal effectiveness of this combination.

Digitalis: Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers The average increase was 45%. Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease. In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured, digitalis toxicity was not observed Since there have been isolated reports of patients with elevated digoxin levels, it is recommended that digoxin levels be monitored when initiating, adjusting, and discontinuing PROCARDIA to avoid possible over- or under-digitalization.

Carcinogenesis, mutagenesis, impairment of fertility: When given to rats prior to mating, nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose.

Pregnancy: Category C. Please see full prescribing information with reference to teratogenicity in rats, embryotoxicity in rats, mice and rabbits, and abnormalities in monkeys.

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness, peripheral edema, nausea, weakness, headache and flushing each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%. Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication. Additionally, the following have been reported: muscle cramps, nervousness, dyspnea, nasal and chest congestion, diarrhea, constipation, inflammation, joint stiffness, shakiness, sleep disturbances, blurred vision, difficulties in balance, dermatitis, pruritus, urticaria, fever, sweating, chills, and sexual difficulties Very rarely, introduction of PROCARDIA therapy was associated with an increase in anginal pain, possibly due to associated hypotension.

In addition, more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients. It remains possible, however, that some or many of these events were drug related. Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2%. Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0.5% of patients

Laboratory Tests: Rare, mild to moderate, transient elevations of enzymes such as alkaline phosphatase, CPK, LDH, SGOT, and SGPT have been noted, and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy. The relationship to PROCARDIA therapy is uncertain. These laboratory abnormalities have rarely been associated with clinical symptoms. Cholestasis, possibly due to PROCARDIA therapy, has been reported twice in the extensive world literature.

HOW SUPPLIED: Each orange, soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine. PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66), 300 (NDC 0069-2600-72), and unit dose (10x10) (NDC 0069-2600-41). The capsules should be protected from light and moisture and stored at controlled room temperature 59° to 77°F (15° to 25°C) in the manufacturer's original container.

More detailed professional information available on request.

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"I can do things that I couldn't do for 3 yrs. including joining the human race again."

Quotes from an unsolicited letter received by Pfizer from an angina patient.
While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] as soon as it became available. The change in my condition is remarkable."

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks, taking fewer nitroglycerin tablets, doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).

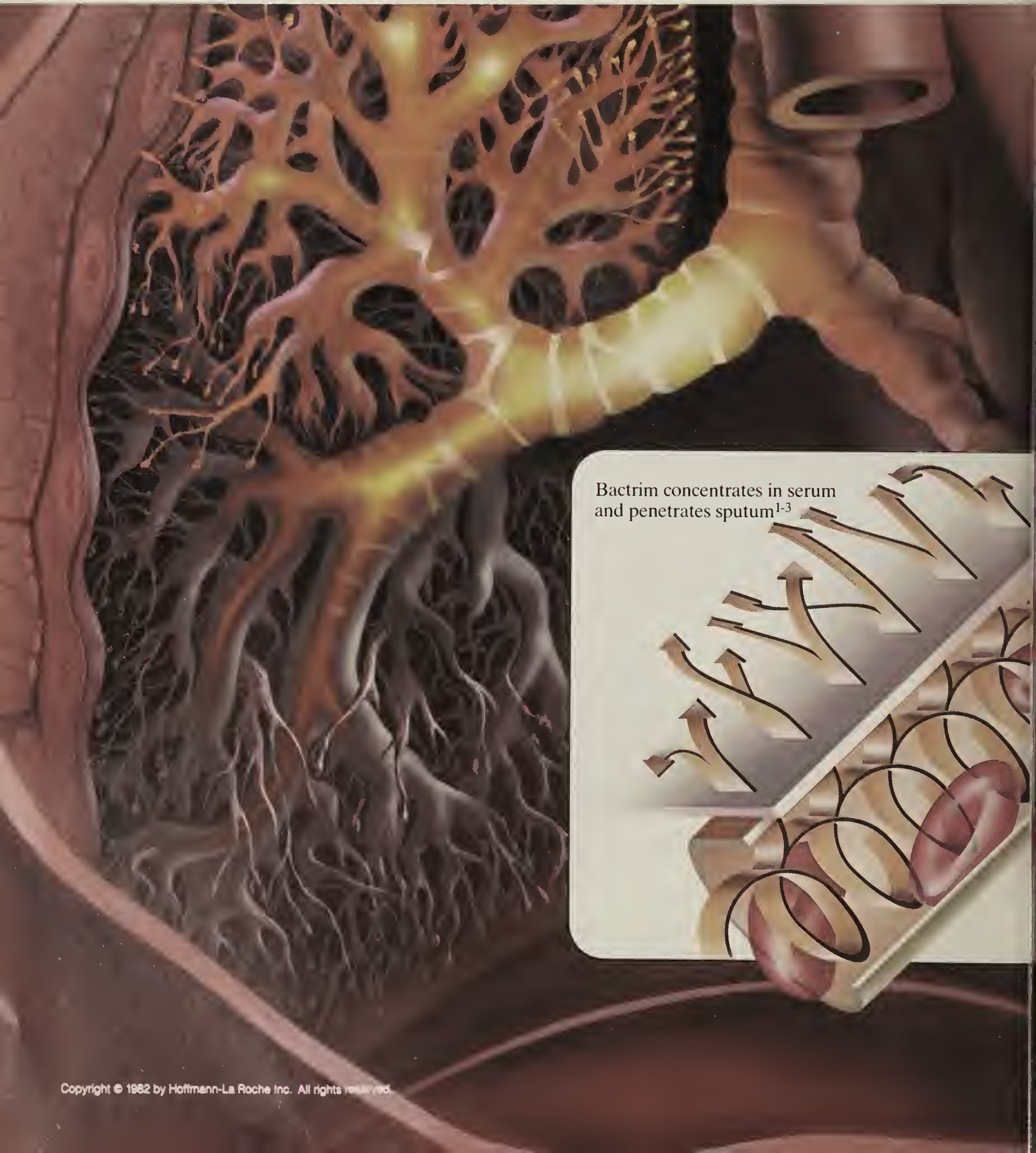
for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

* Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page.*

Bactrim™ attacks the
(trimethoprim and sulfamethoxazole/Roche)
# in acute exacerbations



Bactrim concentrates in serum and penetrates sputum[1-3]

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najor pathogens f chronic bronchitis*

Bactrim clears sputum of susceptible bacteria

In sputum cultures from patients with acute exacerbations of chronic bronchitis, *H. influenzae* and *S. pneumoniae* are isolated more often than any other pathogens.[4,5] One study of transtracheal aspirates from 76 patients with acute exacerbations found that 80% of the isolates were of these two pathogens.[5]

Bactrim is effective *in vitro* against most strains of both *S. pneumoniae* and *H. influenzae*—even ampicillin-resistant strains. And in acute exacerbations of chronic bronchitis involving these two pathogens, sputum cultures taken seven days after a two-week course of therapy showed that Bactrim eradicated these bacteria in 91% (50 of 55) of the patients treated.[6]

ks *H. influenzae*—even
picillin-resistant strains

tacks *S. pneumoniae*

Bactrim reduces coughing and sputum production

In three double-blind comparisons with ampicillin *q.i.d.*, Bactrim DS proved equally effective on all clinical parameters.[7-9] Bactrim reduced the frequency and severity of coughing, reduced the amount of sputum produced and cleared the sputum of purulence.

Bactrim has the added advantages of *b.i.d.* dosage convenience and a lower incidence of diarrhea than with ampicillin, and it is useful in patients allergic to penicillins.

Bactrim also proved more effective than tetracyclines in 10 clinical trials involving nearly 700 patients.[10] Overall clinical condition of the patients, changes in sputum purulence, reduction in sputum volume and microbiological clearance of pathogens—all improved more with Bactrim therapy than with tetracyclines. G.I. side effects occurred in only 7% of patients treated with Bactrim compared with 12% of tetracycline-treated patients. (See Adverse Reactions in summary of product information on next page.)

Bactrim is contraindicated in pregnancy at term and nursing mothers, infants under two months of age, documented megaloblastic anemia due to folate deficiency and hypersensitivity.

Bactrim DS. For acute exacerbations of chronic bronchitis in adults* when it offers an advantage over single-agent antibacterials.

References: 1. Hughes DTD, Bye A, Hodder P: *Adv Antimicrob Antineoplastic Chemother I/2*:1105-1106, 1971. **2.** Jordan GW *et al: Can Med Assoc J 112*:91S-95S, Jun 14, 1975. **3.** Beck H, Pechere JC: *Prog Antimicrob Anticancer Chemother 1*:663-667, 1969. **4.** Quintiliani R: Microbiological and therapeutic considerations in exacerbations of chronic bronchitis, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts;* Princeton Junction, NJ, Communications Media for Education, Inc., 1980, pp. 9-12. **5.** Schreiner A *et al: Infection* 6(2):54-56, 1978. **6.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **7.** Chodosh S: Treatment of acute exacerbations of chronic bronchitis: results of a double-blind crossover clinical trial, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts. Op. cit.*, pp. 15-16. **8.** Chervinsky P: Double-blind clinical comparisons between trimethoprim-sulfamethoxazole (Bactrim™) and ampicillin in the treatment of bronchitic exacerbations. *Ibid.*, pp. 17-18. **9.** Dulfano MJ: Trimethoprim-sulfamethoxazole vs. ampicillin in the treatment of exacerbations of chronic bronchitis. *Ibid.*, pp. 19-20. **10.** Medici TC: Trimethoprim-sulfamethoxazole (Bactrim™) in treating acute exacerbations of chronic bronchitis: summary of European clinical experience. *Ibid.*, pp. 13-14.

Economical
b.i.d.

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole/Roche)

*Due to susceptible organisms. **Please see next page for summary of product information.**

Bactrim™

(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii*. It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is *not* indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency, pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders Frequent CBC's are recommended, therapy should be discontinued if a significantly reduced count of any formed blood element is noted

Precautions: *General* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin, reassess coagulation time when administering Bactrim to these patients

Pregnancy Teratogenic Effects Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia *Allergic reactions* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis *Gastrointestinal reactions* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis *CNS reactions* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness *Miscellaneous reactions.* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L E phenomenon Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients, cross-sensitivity with these agents may exist In rats, long-term therapy with sulfonamides has produced thyroid malignancies

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN

Adults Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d for 10-14 days Use identical daily dosage for 5 days for shigellosis

Children Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days Use identical daily dosage for 5 days for shigellosis

For patients with renal impairment Use recommended dosage regimen when creatinine clearance is above 30 ml/min If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen Bactrim is not recommended if creatinine clearance is below 15 ml/min

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS

Usual adult dosage 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp (20 ml) b i d for 14 days

PNEUMOCYSTIS CARINII PNEUMONITIS

Recommended dosage 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days See complete product information for suggested children's dosage table

Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100, Tel-E-Dose* packages of 100, Prescription Paks of 20 and 28 *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500, Tel-E-Dose* packages of 100, Prescription Paks of 40 *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml), cherry flavored—bottles of 100 ml and 16 oz (1 pint) *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml), fruit-licorice flavored—bottles of 16 oz (1 pint)

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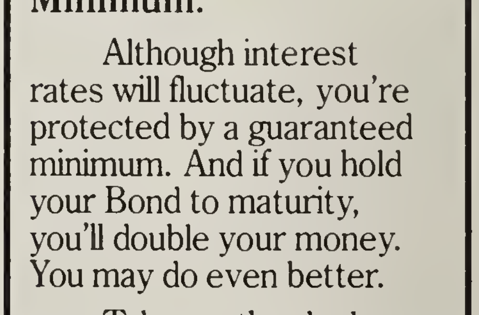

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Your order placed now will enable us to print a sufficient quantity to meet the need and demand. The cost is $5 per copy for members and $15 per copy for non-members and non-MDs.

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Put a miracle in your pocket; carry an organ donor card

By Joyce A. Heyboer
Birmingham

In June 1981, the American Medical Association Auxiliary passed a resolution encouraging the establishment of state organ donation weeks across the nation. The Auxiliary in the state of Washington has had a successful organ donation week for two years.

We in Michigan have asked Governor Blanchard to proclaim April 24-30 as the First Annual Organ Donation Awareness Week in the state of Michigan. Our theme for the week will be, "Put a Miracle in your Pocket — Carry an Organ Donation Card."

Transferring

In keeping with its goals of service and tradition of seeking better physical and mental conditions of mankind, the Michigan State Medical Society Auxiliary will endeavor to improve public awareness and acceptance of the concept of organ donation, emphasizing to both the donor and family the "transference of life," rather than the ending of life. We will be working in coalition with other organizations, namely, the Michigan State Medical Society, National Kidney Foundation of Michigan, the Organ Procurement Agency of Michigan, Michigan Eye Bank and the National Institute for Burn Medicine.

Advances in medical science now make it possible to replace a variety of malfunctioning human organs. For instance, since 1954, thousands of kidney transplants have taken place. Techniques for transplanting kidneys and corneas are currently the most advanced, but progress also has been made in overcoming transplantation problems connected with the liver, pancreas, heart, bone and other tissues. Many lives are lost every year because there are not enough donors of kidneys and other organs. A donated organ, successfully transplanted, is literally the gift of life.

The Michigan Uniform Anatomical Gift Act provides distribution with each driver's license and renewal of the green Organ Donor Information brochure and a donor label to be attached to the back of one's driver's license.

Donating process

The necessary steps to become an organ donor are:

1. Fill out an Organ Donor Label; Use the label on your driver's license that comes with the renewal notice, or request a donor label from the Organ Procurement Agency of Michigan, 1-800-482-4881.
2. Sign the label in the presence of two witnesses; using family members as witnesses assures that they understand your wishes.
3. Tell your family, friends and physician; failure to communicate your desire to be a part of the donor program may cause delays which could make donation impossible.
4. Place your label on your driver's license; this completed label could be a "Miracle in your Pocket."

A new descriptive brochure is being prepared by the Michigan State Medical Society Auxiliary in cooperation with the Michigan State Medical Society and the other four participating state-wide organizations. Copies of this brochure for your office are available from Mrs. Donald J. Heyboer, 790 S. Glenhurst, Birmingham 48009. We appreciate your cooperation in the state-wide distribution of this brochure to facilitate organ donor awareness throughout the state of Michigan.

Mrs. Heyboer is Health Projects chairman for MSMS/A.

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Worth sharing

From time to time *Michigan Medicine* will reprint excerpts of well-put essays on the current medical scene. The following example was suggested to us by enthusiastic MSMS members who wished to see these comments further disseminated. Have you seen something good lately you would like to share with your colleagues? Please contact the editor, and we will work together to get the good word out.

The bomb: man's thinking must change

By Everette Gustafson, MD
Pontiac

Doctor Gustafson

The following is reprinted with permission from the Oakland County Medical Society Bulletin.

Our problem, in 1954, was a simple one. The naval medical officers attending an Atomic Warfare class were given the following scenario:

> A bomb, called the Hydrogen Bomb, carrying the explosive destructive force equivalent to that delivered by a train of flat cars one and one-half miles long, each loaded with TNT, is dropped on the capitol.
>
> Prepare a civil defense, as well as a military plan, to manage the local response.

After thoughtful deliberation, we presented a plan based on the knowledge available. We were wrong. Totally wrong! We were thinking of conventional weapons. We forgot (perhaps, did not comprehend) the injunction given to us by Albert Einstein when he said: "The bomb has changed everything except man's thinking."

Our plan failed because we were unaware of the destructive forces unleashed by the detonation. The center of our plan (Bethesda Naval Hospital) was no more. Ten minutes after the explosion, Society, as we knew it, was no longer operative.

Today, 28 years later, we have made great progress. Our bombs now carry the destructive force equivalent to a train of flat cars 200 miles long, each loaded with TNT. Our thinking has *not* changed.

We think we can "win" a nuclear war! Fifty million bodies are predicted as the bounty from multiple explosions. My mind can comprehend our concern over a small child, accidentally trapped in a well shaft . . . an empathy of this size is mentally managed without significant alteration. But 50,000 traffic victims in one year! That's bodies! It is blotted from comprehension by the subleties of denial. Yet, 50,000,000 bodies is a calculated loss in a nuclear holocaust. It is true, as J.K. Gailbraith has said. "The mind resists involvement with horror." Our thinking has not changed.

Can intelligent men, fully cognizant of the course of history and their contribution to the community, so live that, when the facts are known, they are uninvolved? As we observe the machinations of our destructive force, the immature debates at the conference table and the myopic vision of our elder statesmen, we become appalled at our inability to stop the known course of human events which can now only lead to total destruction. This state of affairs is now called "M.A.D.," meaning mutual assured destruction. The acronym fits the condition; we are mad.

Is there not some voice, somewhere, however weak, that will be heard? I think that voice is ours, the medical community. Ours is the legacy of service to mankind; ours is the humanitarian voice that seeks the eradication of that which demeans human dignity. We physicians speak a common language, worldwide, because we share a special knowledge. We know the symptoms of radiation disease; we know the effects of trauma; we know the results of rampant infection; we know the breakdown of a society that is fragmented by dissension and hatred. All of us share, in some way, the holocausts of the past and in the scenes of the present disturbance. We view them with disgust and revulsion. Most of us view the future with fear; our children fear nuclear war the most. "Hu-

Continued on page 172

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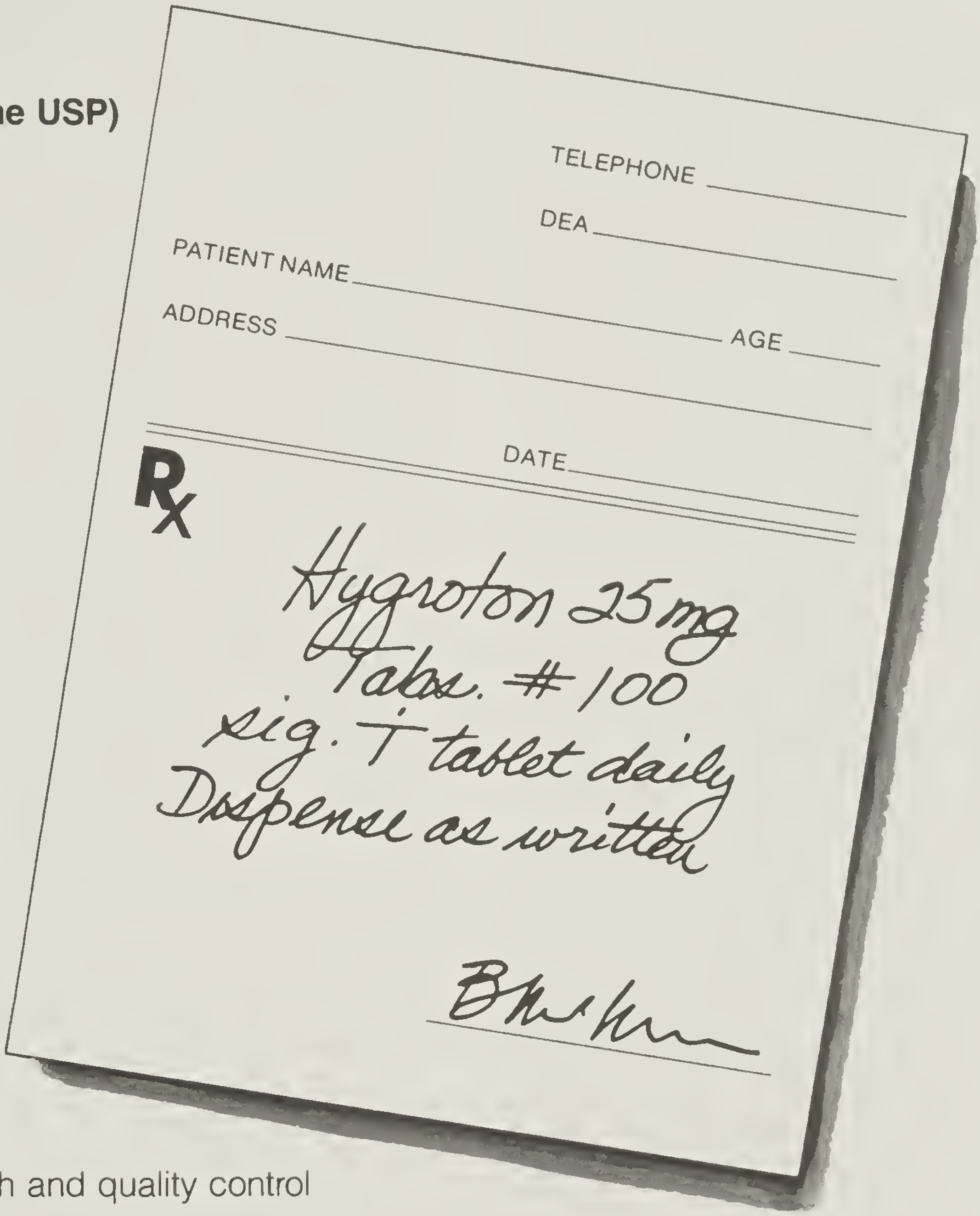
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BRIEF SUMMARY

Indications: Hypertension, adjunctive therapy in edema.

Contraindications: Anuria, hypersensitivity to chlorthalidone or other sulfonamide-derived drugs.

Warnings: Should be used with caution in severe renal disease, impaired hepatic function or progressive liver disease. May add to or potentiate the action of other antihypertensive drugs. Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. There is a possibility of exacerbation or activation of systemic lupus erythematosus with thiazides, which are related to chlorthalidone. This has not been reported with chlorthalidone. Thiazides cross the placental barrier and appear in cord blood. Use in pregnant women requires that the anticipated benefits of the drug be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. In nursing mothers, thiazides cross the placental barrier and appear in breast milk. If use of the drug is essential, the patient should stop nursing.

Precautions: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. All patients receiving chlorthalidone should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Hypokalemia may develop with chlorthalidone as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather. Hyperuricemia may occur or gout be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged and latent diabetes mellitus may become manifest. Chlorthalidone and related drugs may increase the responsiveness to tubocurarine. The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Chlorthalidone and related drugs may decrease arterial responsiveness to norepinephrine. If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic therapy. Chlorthalidone and related drugs may decrease serum PBI levels without signs of thyroid disturbance.

Adverse Reactions: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis; dizziness, vertigo, paresthesias, headache, xanthopsia; leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia; purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis) (cutaneous vasculitis), Lyell's syndrome (toxic epidermal necrolysis). Orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates or narcotics. Other adverse reactions include hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, impotence. Whenever adverse reactions are moderate or severe, chlorthalidone dosage should be reduced or therapy withdrawn.

Usual Dose: One tablet daily

How Supplied: Tablets—100 mg (white, scored), 50 mg (aqua) in bottles of 100, 1000 and 5000; 25 mg (peach) in bottles of 100 and 1000; unit-dose blister packs, boxes of 100 (10 x 10 strips).

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MEDICAL NEWSFRONTS

Ann Arbor diabetes researchers seek volunteers

The Diabetes Control and Complications Trial (DCCT) has been organized by the National Institutes of Health to answer this important question: Does normalizing blood glucose help to prevent or ameliorate diabetic complications?

The largest prospective, randomized study of this problem ever undertaken, it will have 21 centers throughout the United States and Canada (including Michigan) and will proceed in ithree phases: a planning phase, begun in February 1982 and just completed; a two-year feasibility trial to begin patient recruitment (started in February 1983); and the full-scale study, to include about 1,000 patients over an eight to 10 year period.

The feasibility trial has four goals: (1) to recruit patients with type I (insulin-dependent) diabetes who fulfill the eligibility criteria (see box) and who are willing to be randomized to either a "standard" or an "experimental" therapy; (2) to determine whether a clinically and statistically significant difference in the level of blood glucose control can be maintained between the two groups over a two-year period; (3) to establish the safety, efficacy, and acceptability of the two treatment regimens; (4) to determine whether the biochemical and endpoint measurements outlined can be measured and documented with acceptable precision.

Eligible volunteers will be assigned to either a "standard" or "experimental" treatment group using a statistical randomization procedure.

Diabetes Control and Complications Trial

Basic Eligibility Criteria

— Insulin-dependent diabetic patients between 13 and 40 years

— Serum creatinine ≤ 1.2 mg/dl

— Glycosylated hemoglobin (A_1) value greater than three standard deviations above the mean of a nondiabetic population (approximately 8%)

— Informed consent from all participants. In addition, informed consent from parent or guardian of participants less than 18 years of age

— Absence of advanced complications of diabetes, e.g., severe retinopathy or nephropathy

Primary Intervention	**Secondary Intervention**
No retinopathy as judged by stereo color fundus photography	Minimal background retinopathy (at least 1 microaneurysm in either eye)
Duration of diabetes 1-5 years	Duration of diabetes 1-15 years
Corrected visual acuity at least 20/25 in both eyes	Corrected visual acuity at least 20/32 in both eyes
Absence of proteinuria	Absence of proteinuria

THE BOMB/*Continued*

manity has no more vital need than the avoidance of a nuclear catastrophe."

Yet we stand at an abyss . . . thinking the unthinkable, planning for the unwanted event, assessing motives of others that are no less our own, unable to change our manner of thinking. Strange as it is, our emotions seem capable of straddling any schism, even though the intellect views events realistically.

Does it not seem incongruous that those who work in Radiology wear photoplates, which are used to detect incidental radiation. Strict limits are enforced in the Radiology area, and still we talk of limited nuclear wars. When a treatment requires a modality that includes radiation, we employ stringent controls to protect those engaged in rendering that care. Still, we listen to those who propose more and more nuclear arms.

Is it not unethical to plan medical treatment for the population exposed to nuclear radiation when we know it will not be available? Is it not unethical to allow our patients to trust blindly in our expertise when we know we have nothing in our armamentarium that would warrant that trust? Is it not unethical to suggest that we will be available . . . when we, being centrally located, are at equal risk of annihilation?

Tell us, please, you who deal with emotions, how to deal with the "numbing effect" of those who survive the holocaust. How do you propose management of those patients who, needing a physical reference point, cannot find one because there are none? Literally and figuratively, we cannot go back home again. A meaningful society, as we know it, will no longer exist.

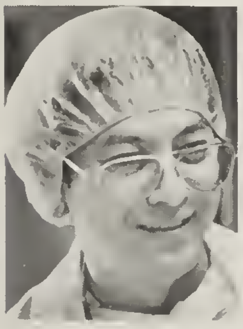
Our medical community is a multi-national, multi-racial, multi-cultured, multi-splendid group which, if employed as our philosophies direct, could raise the loudest of all voices in protest. To accomplish this purpose will require scholarship that will allow a change in our thinking. If we are, as we profess to be, the protectors of life, promoters of health, practitioners of preventive medicine, holistic in our outlook, or just plain self-seekers, let's act like it. The nuclear threat is real, there is no defense, it cannot be limited, it cannot be won. It is horrendously expensive and offers no security.

Let us invoke a new awareness. As a man, I am an American; but as a citizen, I am of the world. Let us reaffirm that here the activities of man are judged not as virtuous, but as shining; not as just, but as great; not as reasonable, but as extraordinary. Out of disgust with the past and fear of the future, let us commit ourselves to the task . . . to view the society in which we live as worldwide and change our thinking.

Randomization is necessary to limit the impact of any confounding variables that might otherwise be unequally distributed between the two groups. Treatment of patients in both groups will emphasize (1) avoidance of glycosuria and/or hypoglycemia and ketonuria, and (2) maintenance of normal growth and development and ideal body weight.

The standard treatment regimen is meant to approximate the therapy that most insulin-dependent diabetic patients are now receiving, whereas the experimental treatment regimen is designed to achieve and maintain as near-normal glucose control as possible without significant hypoglycemia.

Volunteers will be needed. Basic eligibility criteria are listed in the accompanying box. We encourage anyone to contact Fred Whitehouse, MD, or Dorothy Kahkonen, MD, at Henry Ford Hospital, Detroit, (313) 876-2131 or 876-2141 or 876-7035 for further information. Appropriate volunteers are needed for this important study.


Doctor Lim

A new procedure that dramatically reduces the pain and discomfort suffered by patients following many serious surgeries has been instituted by a St. Joseph (Flint) Hospital anesthesiologist.

Epidural morphine, a new pain medication technique for relief of postoperative "wound" pain, is administered to patients directly through a catheter to the dura membrane surrounding the spinal column. The morphine, which is given in small doses, usually four-to-six milligrams, is absorbed by the dura and eventually dulls the opiate receptor. That effectively eliminates pain for 18-to-24 hours, according to Kheng Bee Lim, MD, chief of anesthesiology at St. Joseph.

By leaving the motor function intact through epidural morphine, patients are more able to do deep breath exercises and coughing to prevent lung disfunction following surgery, as well as move in a relaxed manner.

The epidural morphine treatment is usually continued from two to three days following the operation, with constant monitoring by nurses.

Although the current thrust of the epidural morphine is in the postoperative care, Dr. Lim says that the use of the treatment will expand to palliative (non-curable) care for cancer patients. It will provide long term relief for cancer pain, without depression of the intellectual, sensory, or motor functions, he says.

The only major risk involved with the procedure is breathing disfunction, if too much morphine is applied.

Audio Medical News (AMN) is a new **socio/economic audio cassette program** co-produced by the AMA and Audio-Digest Foundation, a subsidiary of the California Medical Association. Audio cassettes are being prepared twice each month to meet the informational needs of the busy physician and other health care professionals.

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The annual charge for this service is $96.00. Brochures and more complete information on AMN are available from Robert L. Bonin, Office of Specialized communications, AMA, 535 N. Dearborn, Chicago, 60610.

At a time when their health care needs are probably increasing, more than 350,000 **unemployed Detroiters** have lost their job-related health care benefits. What services do they delay or forgo?

The University of Michigan has received $255,000 from the Robert Wood Johnson Foundation to answer these questions and document the magnitude of the health care problems of the unemployed and their families.

With some additional support from the Veteran's Administration, the U-M also will document the special needs and health care use patterns of unemployed veterans. Vietnam veterans often have low seniority and are among the first to be laid off.

A new **"transitional" medical training** program for graduate physicians will begin at St. Joseph Hospital (Flint) July 1. This program allows new physicians to work in several medical specialty areas before entering a specific residency program.

Between January 15 and January 28, one fatal case of **Reye's Syndrome** (RS) was reported in a 20 month old child from Wayne County. This is the first RS death of this reporting year. A total of five cases of RS have been reported in Michigan children since October 1. A total of 10 and 13 cases had been reported during the same reporting interval during the 1980-81 and 1981-82 reporting year.

Scattered outbreaks of influenza-like illness in schools and nursing homes across the state continue to be reported. During the past two weeks, we have noted an increase in reports of community transmission. Schools in 11 different areas have closed. Reports of influenza-like illness (received primarily from schools) since the beginning of December are up approximately 10 percent from two years ago when a similar type A influenza virus circulated.

All influenza virus isolates obtained to date by our MDPH viroloy laboratory have been type A (H3N2) isolates. Tupe A (H3N2) influenza virus is predominating this year across the U.S. although a single sporadic isolate of type B influenza virus was grown from an ill individual in Houston and two sporadic isolates of type A (H1N1) influenza virus were grown from ill individuals in Chicago.

The effectiveness of interferon in treating relapsing **genital herpes** is being tested at the Clinical Virology Research Center of Wayne State University School of Medicine.

This is the only study of its kind in the United States; however, a similar study is being conducted in Finland. The center is seeking 40 men and 40 women for its study.

"It is hoped that interferon will shorten the duration of relapse, prevent relapses while under interferon therapy and perhaps even prevent future relapses once therapy is

Continued on page 178

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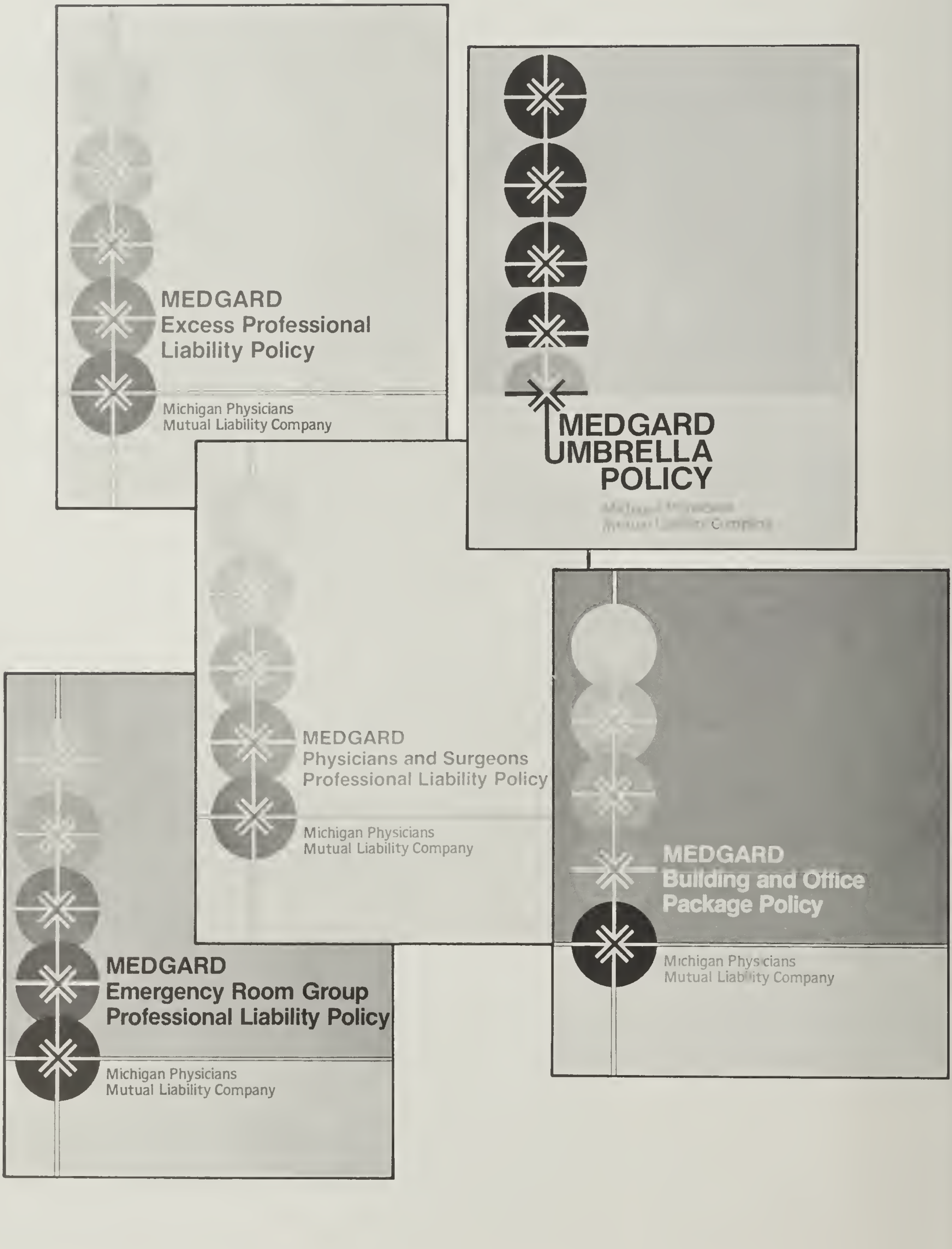

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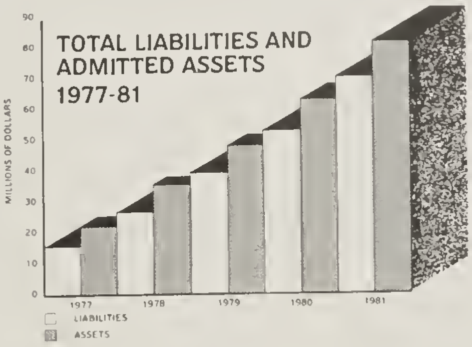

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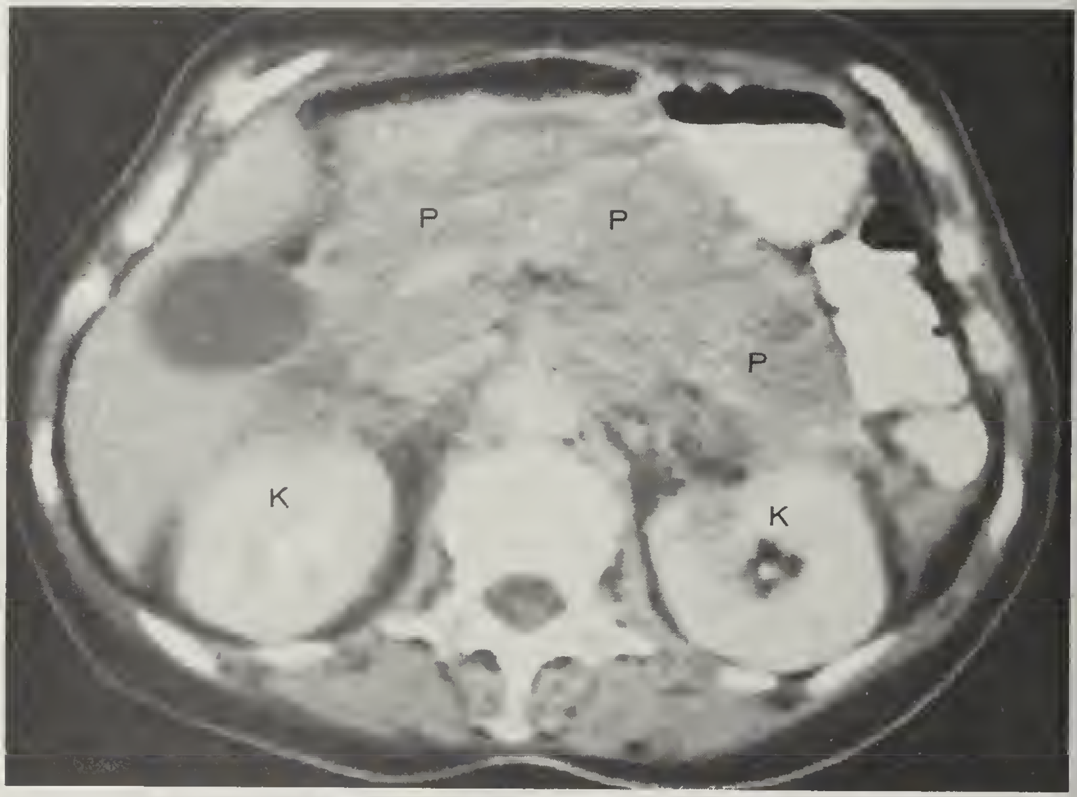
On beyond the CT Scanner: Michigan doctors reviewing radiologic trends

By Willah Weddon
Stockbridge

Doctor Glazer



CT scan through the abdomen shows an enlarged pancreas (P) which was biopsied using CT and proved to have lymphoma. Before CT, this patient probably would have gone to exploratory laparotomy for diagnosis. K = kidneys.

This is a very exciting time for diagnostic radiology. It has moved from the era of plane film radiography to digital imaging which is capable of identifying previously undetectable pathologic states or lesions in the body.

Within the next several years the precise roles of nuclear magnetic resonance (NMR), computerized tomography (CT), ultrasound and other radiologic modalities will be evaluated at centers such as the University of Michigan Hospital.

"Our ultimate goal as radiologists is to help the patient," says Gary M. Glazer, MD, director of the Division of Body Computed Tomography and assistant professor of radiology in the Department of Radiology at the U. of M. Hospital. "We can do so by using the modalities in our radiological armamentarium which are cost-effective, least invasive and most accurate."

Mrs. Weddon is a Lansing area freelance writer.

Doctor Glazer, who trained at the University of California, San Francisco, in diagnostic radiology with sub-specialization in body computed tomography and ultrasonography, provided the following information for ***Michigan Medicine.***

CT scanners

A CT scanner is basically an X-ray machine with multiple X-ray detectors. A scanner obtains views in multiple projections and with computer manipulation of the X-ray data, images are constructed. The machine produces images of a thin cross-section of the body.

The CT scanner, unlike conventional X-rays, produces a tomographic image, i.e., a thin section instead of a composite image. CT scanners also have much greater contrast resolution than conventional X-rays. For example, they can demonstrate differences in the various soft tissues. They can, in the head, distinguish cerebrospinal fluid from brain tissue; this is not possible using conventional radiographs. Likewise, in the body, CT scanners can provide clear demonstration of internal organs such as the liver, spleen, pancreas, kidneys and adrenal glands.

There have been many major advances in non-invasive diagnosis made possible by CT scanners. In the brain, for example, tumors, infarction, infection, hemorrhage and hydrocephalus can be diagnosed using CT. In extracranial tissues, CT scanning can diagnose tumors, infections or traumatic sequelae, in many instances without the need for more invasive procedures.

In many cases, CT scanning has obviated the need for exploratory surgery. It is also useful for evaluating extent of disease as well as response to therapy in cancer patients.

Although CT scanners have been of limited value in the chest, because of long scanning times, current scanners are able to image the chest without image degradation caused by

Continued on page 178

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biological (respiratory or cardiac) motion. Because images of great clarity can now be produced, CT scanning of the chest has found increasing application. These uses now include evaluation of the solitary pulmonary nodule, staging of lung cancer, evaluation of the pulmonary hilum, detection of otherwise radiographically occult lung metastasis and evaluation of patency of coronary bypass graft.

An additional area of intense interest today is CT evaluation of the spine. A CT scanner, in many instances, can detect herniated discs, thus obviating the need for myelography.

Developments in real-time ultrasound have largely replaced head CT scanning in the evaluation of varied pathologies of the newborn brain, however, particularly in the areas of intracranial hemorrhage and hydrocephalus. This is because, in large part, the ultrasound examination can be performed portably so the newborn need not be removed from the nursery. It is also due to the fact that serial examinations are often necessary in those newborns with intracranial hemorrhage and that ultrasound uses no ionizing radiation, a great advantage compared to CT scanning.

Dangers of X-ray?

In terms of patient dose, CT scanner exams are approximately equal in skin radiation dose to an IVP or GI series.

Because the X-ray beam is very finely collimated, however, there is very little "scatter" so the dose outside the scanning plane is minimal. As a result, the dose to the reproductive organs is very small from a CT examination. Significant exposure to the reproductive organs only occurs if they are included in the scanning plane. Furthermore, a single CT examination may provide enough information to answer the clinical problem. Multiple X-ray examinations, which would otherwise cumulatively increase dosage to the patient, thus can be avoided.

NMR

Nuclear magnetic resonance imaging (NMR) is a revolutionary development in diagnostic radiology. Unlike CT scanners, it uses no ionizing radiation of any kind, thus there is no radiation dose to the patient. It uses the magnetic properties of certain elements to produce images; currently the most medically useful images are proton images.

Although preliminary results suggest that NMR may replace CT scanning, in certain conditions (such as detection of demyelinating disease), it is somewhat premature to state in which areas the two modalities will be complementary or in which NMR will replace the CT.

The advantages of NMR, compared to CT, are:

1. It uses no ionizing radiation.
2. Contrast resolution for soft tissue lesions is greater than contrast resolution of CT.
3. Images can be obtained in any projection, i.e., direct coronal, sagittal or oblique planes. (In CT scanning at the present time, for body imaging, only the transverse plane can be directly imaged.)
4. NMR, unlike CT, is potentially capable of evaluating biochemical processes, for example: the relative amounts of ATP, AbP. This may prove valuable in identifying areas of tissue ischemia.
5. Potential for non-invasive measuring blood flow.

The disadvantages of NMR compared to CT:

1. At the current time spatial resolution is poorer for NMR compared to CT.
2. Image acquisition time is longer for NMR, requiring several minutes per imaging sequence. (The CT scanner currently requires two seconds or less for image acquisition.)
3. NMR units are currently more expensive than CT scanners and are less available.

There are very few NMR units operating in the United States today though Doctor Glazer points out the University of Michigan is now constructing an NMR facility.

"The Department of Radiology at the University Hospitals will have an operating NMR unit in the late fall of 1983," he said. "It will be the first in the state."

stopped," says Clinic Director Lawrence Crane, MD, assistant professor of internal medicine at WSU School of Medicine and chief of infectious disease at Harper-Grace Hospitals.

Studies recently reported by Wayne State University researchers indicate that large quantities of interferon are present at the site of a herpes infection. This has lead the WSU physicians to speculate that the compound may be an effective herpes treatment.

Wayne State University has received national recognition over the past 20 years for its research in clinical virology using anti-viral drugs. A. Martin Lerner, MD, formerly professor of internal medicine and chief of infectious disease at the WSU School of Medicine, spearheaded the initial laboratory studies of herpes and interferon. He is serving as an advisor to the current patient study.

The Clinical Virology Research Center is located in the Detroit Receiving Hospital/University Health Center in the Detroit Medical Center. For further information, call the Clinic at 313/494-4229.

Henry Ford Hospital's **cancer program** recently received a three-year unconditional approval by the Commission on Cancer of the American College of Surgeons. The approval indicates that all elements are in place and functioning to provide education, multi-specialty care and quality control for management of cancer patients.

The Commission on Cancer has a total of 989 approved cancer programs nationwide.

HFH's Tumor Registry, which keeps track of all patients with identified cancer, has been operative since 1958 and is a requirement for approval of a cancer program.

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Hospice: a rapidly-growing health care delivery segment

By Lenora Finn Paradis
E. Joseph Alberding, MD
Lansing

In June, 1980 *Michigan Medicine* featured an article on hospices as alternative forms of medical care for the dying. Focusing on the development of hospice programs throughout the State, the article described the benefits of hospice care. *Michigan Medicine* ran a second article in April, 1981, updating physicians on state legislation for hospice. This is the third in the series of articles which describes the growth in the number of programs and the response of physicians toward hospice care.

To US health care policymakers, the word "hospice" signifies the institutionalization of a growing interest in the quality of death and the medical, legal, social and ethical issues surrounding death and the prolongation of life through technological support systems.

Hospice is a "medically directed, nurse-coordinated program providing a continuum of home and inpatient care for the terminally ill patient and family. It employs an interdisciplinary team acting under the direction of an autonomous hospice administrator," according to the Flexner Report of 1978.

Hospice also represents an organized approach to health care reform which has widespread public support, and which seeks to participate in governmental systems of health care reimbursement. In September, 1982, after much lobbying by the National Hospice Organization (NHO), the US Congress passed PL 97-248, an act that will provide Medicare reimbursement for hospice care beginning September 1, 1983.

Currently, Michigan law (P.A. 293 of 1980) requires hospice programs to be licensed under the Public Health Code. However, rules have not been promulgated to provide licensing criteria, and the Department of Public Health will not be able to grant licenses to hospice programs until such rules have been promulgated.

In addition to a license, a hospice program also needs a "certificate of need" — a document from the State attesting to the need for the program. Recently passed legislation waived this requirement until 1985 in order to provide hospice programs with an opportunity to become established.

Nationally, Medicare reimbursement for hospice care will be available as a benefit once rules are promulgated. The anticipated date for rule passage is November, 1983. Currently, many third party payors provide hospice care as an optional reimbursement benefit.

Both the State and Federal legislation require that a physician certifies that a patient is terminal with "six months or less to live," before the patient enters a hospice program. Moreover, all hospice programs are required to have a medical director and to involve the physician in the care of the patient.

Many physicians working with hospice programs have volunteered their time although a few are paid for full-time work. As Charles O'Shaughnessy, Medical Director, Hospice of Southeast Michigan noted, "I think hospice is something few physicians were willing to become involved with for a variety of reasons . . . However, over time I think it's a program of care they will appreciate and seek to become a part of."

Ms. Finn Paradis prepared this report as part of work toward a doctoral degree at Michigan State University in medical sociology. Cooperating on the report was Doctor Alberding, who serves as chairman of the MSMS Liaison Committee to the Michigan Department of Public Health.

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In 1978 only one state, Connecticut, had passed legislation regulating hospice programs; but by 1982 the number increased to 11 (including Michigan). The number of hospices nationally has grown from a handful in 1978 to more than 800 in 1981, according to the Joint Commission on Hospital Accreditation. More recent estimates place the number of hospice programs at well over 1,000.

In Michigan, the number of hospice programs has escalated dramatically since the first was established in 1978. There are more than 56 operational programs today, and at least six other community groups initiating efforts to develop a hospice program.

Hospice programs come in all types and sizes. The federal standards describe six varieties ranging from institutionally-based programs (those run by hospitals and nursing homes) to community-based, all-volunteer programs. Michigan has at least one program reflecting each variety.

A typical hospice program in Michigan is home based in its orientation toward patient care. It offers a range of services, including basic and skilled nursing, bereavement counseling, social work and psychological counseling, personal care, symptom control, transportation, companionship, errand running, housekeeping and meal preparation.

Hospice programs are dependent upon physician support for their survival, and the physician plays an important role in the delivery of hospice services. It is the physician who decides whether a patient is terminal and in need of hospice care. It is the physician who writes prescriptions used for symptom control — a major segment of the hospice program. It is the physician who is required by law to serve as medical director if a program is to receive any type of reimbursement and to gain legitimacy within the health care system. Finally, it is the physician whom the patient trusts and turns to for advice and assistance.

Physicians are important to area hospice programs in other ways. In the community, physicians often are opinion leaders, especially in matters of health care. Without their support, community-based hospice programs have little chance of getting off the ground. Physicians who view the local hospice negatively can significantly affect their patients' decision to participate.

Often physicians making decisions regarding hospice referral are specialists who have seen the patient

Continued on page 182

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April seminars on physician, hospice

A series of afternoon conferences on "Hospice and the Physician" are planned late in April by the Physician Education Committee of the Michigan Hospice Organization.

Dates and places are April 25, Marquette Holiday Inn; April 26, The Chalet in Gaylord; April 28, Dearborn Hyatt Regency and April 29, Stouffers Inn, Battle Creek.

The conferences will feature keynote speakers Ina Ajemian, MD, of the Royal Victoria Hospital of Montreal, whose topic will be symptom control, and William Lamers, MD, of Calgary Hospice in Alberta, who will discuss developing a hospice program.

The afternoon sessions also will include a panel presentation and legislative update. The panel discussion will be on the hospice concept of the interdisciplinary team approach to patient care.

Cost to physicians is $70. Registration may be made with the Michigan Funeral Directors Association, 2420 Science Parkway, Okemos, 48864.

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for a short period of time (generally less than two years). The physician generally does not have a long history with the patient and his or her family.

The decision to refer a patient to a hospice program provides the physician the emotional reprieve of having to deal with the physical, social and emotional troubles of a dying person. On the other hand, it forces them to acknowledge medical defeat — an admission which is not easy for most physicians to make.

Because of the importance of physicians in the area of hospice care and the factors which influence a physician's decision to refer patients for hospice care, a short questionnaire was designed to obtain basic information regarding physicians' knowledge of and participation in hospice programs throughout the state. The eight-item questionnaire asked physicians if they understood the meaning of hospice care, if they were active on hospice boards, and if they referred their terminal patients to hospice or bereavement programs.

Survey results

Two hundred and fifty-eight active physicians (199 MDs and 59 DOs) specializing in family practice, internal medicine and oncology were selected for the survey sample. One hundred and forty-three physicians responded to the survey (55 percent response rate).

Slightly less than half (46 percent) of the responding physicians had referred patients to hospice programs. Of these who had referred patients, the majority were oncologists or internists. There was no difference in reporting between osteopathic and allopathic physicians.

Slightly over half of the respondents (55 percent) indicated they referred patients and families to bereavement counseling. Oncologists were more likely to refer patients for grief counseling than were either family practitioners or internists.

Physicians with higher numbers of terminal patients are more likely to refer patients for hospice care than are those physicians with fewer terminal patients.

Thirteen physicians with a low number of terminal patients indicated they would not refer patients to a hospice program, but indicated they were willing to serve on a hospice board or committee. This result was surprising. Further analysis of the data shows that 11 of the 13 respondents in this category were family practitioners. Reasons for this outcome are speculative. When asked to discuss the possible meaning of this finding one respondent, a physician, stated, "The result is not terribly surprising when you consider that family practitioners often see themselves as jacks-of-all-trades, a person who can deal with every problem the patient expresses. It's not unreasonable for them to think they can handle the dying patient's problems in the last stages of life . . . Concurrently, this physician is probably supportive of the hospice concept and willing to devote time and energy to the development of one in the community for other physicians to use."

Summary

From this small survey it appears that physicians are conscious of the meaning of hospice and are willing to refer their terminal patients for hospice care. This is an important point, as physicians are socialized and trained to provide whatever steps are necessary to preserve the life of a patient, even though, at times this means employing technology which may only prolong life a few days without improving the quality.

Hospice supporters contend that physician acceptance is crucial but has taken a long time. The early hospice program developed because the traditional system failed to attend to the needs of the dying and their families. Symptom control and bereavement counseling were largely unavailable. As one hospice physician said, "Doctors didn't want to provide morphine to patients because they were afraid they'd become addicted. This is a logical concern for living patients but not so for dying ones. We need to encourage physicians to admit to themselves and their patients that the patient is dying and get on with trying to make the patient as comfortable as possible."

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UPDATED MATERNAL HEALTH DESK REFERENCE CARD NO. 3

(Sponsored and prepared by the Committee on Maternal and Perinatal Health, Michigan State Medical Society.)

*This card replaces the previous card No. 3, "Use and Abuse of Oxytocics."

INDUCTION OF LABOR*

Many obstetric problems necessitate induction of labor. Several agents are available to stimulate uterine activity. This outline offers guidelines for use of these agents and is not intended as an inflexible set of rules. Individualization of each case must always be the responsibility of the attending physician.

I. **Induction of Labor with Living Fetus**

   A. **Maternal Indications:** Common medical problems posing grave threats to the mother may include severe hypertensive disease; diabetes mellitus; severe renal, heart or pulmonary disease; chorioamnionitis.

   B. **Fetal Indications:** Common problems include severe hypertensive disease, chorioamnionitis, prolonged gestation with the cervix favorable for induction, clinical evidence of impending fetal demise (e.g. positive oxytocin challenge test), and premature rupture of membranes with pulmonary maturity.

   C. **Artificial Rupture of Membranes:** Is encouraged as soon as vertex is well applied to cervix and cervix is adequately dilated.

      1. Is usually performed after contractions have been initiated with intravenous oxytocin. May be used alone to initiate labor when the cervix is favorable.
      2. Allows observation of meconium in amniotic fluid.
      3. Often improves quality of uterine contractions.
      4. Allows application of internal fetal monitor.
      5. Should be performed between contractions.
      6. Should be performed with caution if presenting part of fetus is not well applied to cervix.

   D. **Internal Fetal Monitoring:** Strongly recommended.

      1. Intrauterine pressure catheter is more reliable than the external toco in monitoring intensity of contractions and in detecting hypertonus.
      2. Fetal scalp electrode improves accuracy in monitoring beat-to-beat variability, subtle late decelerations, and persistent variable decelerations with poor recovery to baseline.

   E. **Intravenous Administration of Oxytocin**

      1. *Intravenous* oxytocin is the only recommended method of inducing labor. Buccal pitocin and intramuscular oxytocin are contraindicated.
      2. Infusion with an accurate pump is preferable to I.V. drip because it makes erratic dosage much less likely.
      3. Ergonovine maleate and prostaglandins are very strong uterine stimulants and are contraindicated in the presence of a living fetus (exception: voluntary interruption of pregnancy).

F. **Example Dosage Protocol**

1. Establish I.V. with isotonic solution.
2. Put 10 units oxytocin in 2nd liter of istonic solution and piggyback into main I.V. line via infusion pump.
3. Begin infusion at 1-2 milliunits per minute.
4. Increase infusion rate slowly. Watch fetal and uterine response carefully with monitor.

G. **Controversial Situations — Twins, Frank Breech Presentation:**

Current obstetric thinking supports the use of oxytocin in the management of certain twin presentations and frank breech presentations, but extreme caution must be exercised. Amniotic fluid embolism has been associated with the use of intravenous oxytocin.

H. **Bishop Score — To Assess Cervical Responsiveness**

Factor	**Score 0**	**Score 1**	**Score 2**	**Score 3**
Cervical Dilatation	closed	1-2 cm.	3-4 cm.	5 cm. or more
Cervical Effacement	0-30%	40-50%	60-70%	80% or more
Station-Presenting Part	−3	−2	−1/0	+1/+2
Consistency of Cervix	firm	medium	soft	
Position of Cervix	posterior	mid-position	anterior	

1. Total Score = Sum of factors
2. Score 0-4: Approximately 20% failure of induction
3. Score 5-8: Approximately 5% failure of induction
4. Score 9 or more: Failure not expected

I. **Elective Induction of Labor:** Induction of labor strictly for the convenience of the patient and/or the physician is discouraged. The use of oxytocin for *elective* induction does not have FDA approval.

J. **X-ray Pelvimetry:** If cephalopelvic disproportion is not suspected, pelvimetry is not required prior to induction of labor.

II. Induction of Labor After Intrauterine Fetal Death

Because of the emotional stress and the increased risk of clotting disorders in cases of intrauterine fetal death, many obstetricians choose to induce labor promptly rather than waiting for the spontaneous onset of labor.

A. **Fetal Death at or before 28 Weeks' Gestation:**

1. The FDA has approved the use of prostaglandin vaginal suppositories (PGE_2, 20 mgm. per suppository) for induction in cases of fetal death at or before 28 weeks' gestation.
2. One PGE_2 20 mgm. suppository in the posterior vaginal fornix every 3-4 hours is sufficient to induce strong contractions.
3. Laminaria placed in the endocervical canal for 8-12 hours prior to induction may ripen the cervix considerably.
4. Rupturing membranes as soon as possible will augment the induction.
5. Common side effects of PGE_2 include nausea, vomiting, diarrhea and fever. Prochlorperazine and diphenoxylate hydrochloride may be given at the time of induction to reduce these responses.

UPDATED MATERNAL HEALTH DESK REFERENCE CARD NO. 3 (Contd.)

6. Contraindications to the use of PGE_2: active cardiac, pulmonary, renal, or hepatic disease. Additional precautions are found in the package insert.

B. **Fetal Death after 28 Weeks' Gestation**

1. The use of PGE_2 vaginal suppositories to induce labor for intrauterine fetal death after 28 weeks' gestation has not been approved by the FDA. However, many institutions have safely employed PGE_2 suppositories after 28 weeks. Consultation with or referral to one of these institutions is appropriate.

2.-6. Same as above

7. Intravenous oxytocin induction of labor (Part I of the outline) is an alternative to the use of PGE_2 suppositories and can be used as a supplement.

III. **Gestational Trophoblastic Disease**

Molar pregnancies are usually evacuated by suction curettage, followed by gentle sharp curettage. PGE_2 vaginal suppositories and/or intravenous oxytocin are usually not employed to initiate labor. Parenteral oxytocin and/or ergonovine maleate is used during/after evacuation to control uterine bleeding. Consultation with or referral to centers familiar with trophoblastic disease may be helpful.

IV. **Early Second-Trimester Abortion**

If voluntary or medically indicated interruption of pregnancy is needed in the second trimester, it can be accomplished with suction curettage; intra-amniotic instillation of prostaglandin (PGF_2) or hypertonic saline; PGE_2 vaginal suppositories; or with intravenous oxytocin. Because these procedures carry increased risks of maternal morbidity and because the Michigan Supreme Court has made specific recommendations regarding the acceptability of second-trimester abortion, consultation with or referral to facilities designed and approved for these procedures is recommended.

This Reference Card was written for the Maternal and Perinatal Health Committee by John R. Cooley, MD, Kalamazoo, Michigan. (April, 1982)

The above Desk Reference Card describes methods and techniques of clinical practice that are currently acceptable and used by recognized authorities. However, it does not represent official policy or recommendations of the Michigan State Medical Society and its publication should not be construed as excluding other acceptable methods of handling similar problems.

Michigan physicians have role to play in lowering state's infant death rate

By Judith Marr
Editor

There are several ways in which Michigan physicians may work with the Michigan Department of Public Health in its current goal of significantly reducing the state's infant death rate.

Though very recent figures show a rebound from the alarming levels of Michigan infant deaths in 1980-81, MDPH officials nevertheless are looking to the physician population to assist in lowering the infant death rate significantly further.

For the last 10 years, the infant mortality rate has been declining on both national and state levels. However, Michigan has experienced a higher rate than the national rate for nearly every one of those years.

And in one of the greatest yearly increases since World War II, Michigan's infant mortality rate rose from 12.8 deaths per 1,000 live births in 1980 to 13.2 deaths in 1981. The national average in 1981 was 11.8 deaths. Michigan was 36th worst of the 50 states in numbers of infant deaths.

"Although provisional data for 1982 show that the infant death rate in Michigan has dropped to 12.3 as of September, 1982, we still can expect Michigan's rate to be higher than the national average and, in some areas of the state, at least twice as high as the national average," says Jeffrey R. Taylor, PhD, chief, MDPH Division of Maternal and Infant Health.

The department's goal, says Doctor Taylor, is to reduce infant mortality by at least 32 percent, to fewer than nine deaths per 1,000 live births for the state as a whole, and to no more than 12 deaths per 1,000 for any particular geographic area and racial or ethnic group.

The Department hopes to reach those levels by 1990.

The department plans to address the problem by boosting its services to mothers and infants, particularly family planning, comprehensive maternity and infant care, nutrition education (including the Women, Infants and Children — WIC — Supplemental Food Program), perinatal intensive care, genetic services, sudden infant death syndrome grief counseling and apnea monitoring, reducing prenatal exposure to environmental health hazards and by increasing general consumer health education.

Principal among the victims of infant deaths are children of young, underweight, malnourished pregnant women who fail to seek prenatal care. Blacks generally experience a rate double that of their white counterparts.

The rise in the Michigan infant death rate may be linked, MDPH officals speculate, to Michigan's troubled economy; to the fact "that a mother's ability to follow up with prenatal care before the birth and infant care after the birth is much less than what it used to be," as one commented.

To work toward its goal, the Department is offering $1.1 million in maternal and child health block grants to the cities and counties with the highest infant death rates.

Those cities and counties according to Doctor Taylor, are:

Counties

	Infant Death Rate 1979
Cheboygan	26.2
Ogemaw	20.5
Kalkaska	19.7
Alger	18.2
Wayne*	16.9
Missaukee	16.8
Crawford	16.1
Ionia	15.7
Alcona	15.7
Clare	15.4

Cities

	Infant Death Rate 1979
Highland Park**	25.1
Detroit**	21.3
Port Huron	21.1
Pontiac	19.6
Battle Creek	18.9
Flint	18.6
Saginaw**	17.9
Holland	16.6
Inkster	15.6
Burton City	15.6
Kalamazoo	15.5

* Michigan Statute Rate 1979-81 was 13.1

** Already receiving MCH Block grant funds — not eligible for additional infant health promotion grants.

The $1.1 million in maternal and child health block grants is one facet of a multifaceted program to improve child and infant health throughout the state. Most of the communities receiving the grants plan first to concentrate on identifying the problem and its causes before they determine intervention programs.

What may Michigan physicians do to work with the MDPH in this important effort?

The MSMS committees on Maternal and Perinatal Health and Public Health are examining the available information and will make their recommendations in the near future.

In the meantime, suggests Doctor Taylor, physicians may:

1) Serve on community infant health promotion action committees as expert professional participants.

These committees may study patterns of infant deaths, he says, look for preventable factors in these deaths, identify available community resources and service groups which could help improve the situation, plan an infant death prevention program and evaluate their results in working toward the goal of nine deaths per 1,000 live births in the county, with no more than 12 per 1,000 live births for any racial group or geographic location.

2) Refer patients to WIC and other helping services.

3) Organize charity clinics in hospital settings where physicians donate their time one or two half-days per month. Says Doctor Taylor, "If hospital nutritionists, medical social workers and public health nurses are included in the clinic team, it has been proven that perinatal mortality rates can be cut substantially."

This approach has been carried out successfully by Butterworth Hospital physicians for several years, doctor Taylor points out.

4) Continue to provide service to the unemployed and uninsured, especially pregnant women and infants to 18 months of age.

"We have over 750,000 unemployed in Michigan, many with wives and young children," reminds Doctor Taylor. "Thousands exhaust their unemployment benefits each month, cannot afford health insurance and cannot qualify for Medicaid."

On behalf of this same group, MSMS President James H. Tisdel, MD, who also chairs the MSMS Committee on Humanitarian Service, issued a call for action Feb. 10 to all MSMS members.

Doctor Tisdel called for a personal commitment from every physician, to shoulder part of the responsibility to meet the health needs of the unemployed.

"It is a responsibility physicians cannot neglect," said Doctor Tisdel.

COORDINATOR OF BURN SERVICE

Hurley Medical Center, a 573-bed teaching medical center with University affiliation in Flint, Michigan, is recruiting a quarter-time Physician as Coordinator of its Burn Program.

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NEW MEMBERS

Members of the Michigan State Medical Society join in welcoming the following new members into a progressive state medical organization. MSMS is dedicated to promoting the science and art of medicine, the protection of the public health, and the betterment of the medical profession. Each new member is encouraged to join with other MSMS members at both the local and state levels in achieving these goals.

Gregory L. Adams, MD PD
2 Hospital Dr.
Berrien Center 49102

Satish K. Arora, MD PD/PDE
150 Delaware St.
Sandusky 48471

Niksa Aviani, MD AN
1521 Gull Rd.
Kalamazoo 49001

Abdul M. Bhat, MD PD/NPM
One Hurley Plaza
Flint 48502

James S. Campbell, Jr., MD FP
632 North Ave.
Battle Creek 49017

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15515 Longmeadow
Dearborn 48120

Arthur R. Euler, MD PD/GE
The Upjohn Co. Unit 7219-242
Kalamazoo 49002

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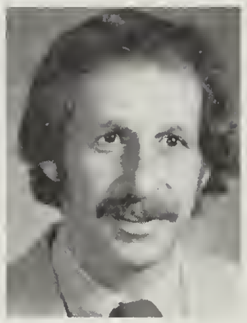
NEWS

By Sheri W. Greenhoe East Lansing

Doctor Haddock

Doctor Jones



Doctor Markel

Doctor Schindler

Recipient of the 1982 Mary Kirkpatrick Fellowship Award is **Bruno Delahaye, MD,** U-M nephrology research fellow. He was selected by the school's department of internal medicine. The award supports the attendance of a fellow at the American Society of Nephrology conference. . . . New president of the Oakland County Medical Society is **Peter A. Duhamel, MD,** Rochester surgeon. . . . **Benjamin B. Blum, MD,** Petoskey, was honored by the Michigan chapter of the American College of Physicians recently for his long standing service and support of the organization. . . . New president of the Michigan Society of Pathologists is **Sheldon M. Markel, MD,** of Ann Arbor. Doctor Markel is head of the department of pathology and director of clinical labs at St. Joseph Mercy Hospital. . . . First recipient of the St. Mary's Hospital Award is **George T. Aitken, MD,** Grand Rapids. The award recognizes his service to the hospital and to crippled children. . . . **Richard R. Neubig, MD, PhD,** a University of Michigan Hospitals physician, has been named a 1983 Fellow by the John A. and George L. Hartford Foundation of New York City. He will receive $105,000 over three years to support early stages of his medical research career. . . . A color photograph of **Frederick C. Swartz, MD** was hung in the Burcham Hills Health Care Center, East Lansing, in honor of his service as first and only medical director there. He has practiced in the Lansing area for more than 40 years, with special attention to the field of geriatrics. . . . **Douglass A. Haddock, MD,** Kalamazoo, is a candidate for the office of president-elect of the American Academy of Family Physicians. He also was one of two MSMS members elected to the board of directors of the AMA Council of Medical Specialty Societies. **William C. Montgomery, MD,** Detroit also was elected. . . . **Charles Zimont, MD,** Constantine, was inducted as an honorary member of the Michigan High School Football Coaches Association as a result of more than 25 years of volunteer medical services to the local high school team. . . . **Clarence S. Livingood, MD,** Grosse Pointe, was recently awarded an honorary Doctor of Science degree from his alma mater, Ursinus College in Pennsylvania. He was honored for having "dedicated most of his professional life to the specialty of dermatology" and his having "labored untiringly to improve the effectiveness and the standards of performance of the specialty." . . . New Chief of the Divisions of Oncology at Wayne State University School of Medicine and at Harper-Grace Hospitals is **Laurence H. Baker, DO.** He has served as associate chairman of the Department of Oncology at the Detroit Medical Center institutions for the past two years. . . . **David G. Anderson, MD, FACS,** Ypsilanti, authored an article on cesarean section in the January, 1983 issue of the Bulletin of the American College of Surgeons. . . . The late **Paul V. Woolley, Jr., MD,** is the subject of the entire Winter, 1983 issue of *Pediatric Consultant,* a publication for the medical community from Children's Hospital of Michigan. Doctor Woolley was a professor and chairman of the WSU Department of Pediatrics and was Pediatrician in Chief at Children's Hospital."The Woolley Era" began there in 1946, and he continued to do research and treat patients until his death in 1982. . . . **L. Jeffry Price, MD,** Grand Rapids, is the author of "Cecropia Moth," a poem featured in the January 21, 1983 issue of *JAMA*. . . . "Foreign Medical Graduates in the United States," a film produced by the Educational Commission for FMGs and created by **Yvan Silva, MD,** Detroit, was awarded a Bronze Medal at the New York International Film and Television Festival. The film was produced on location in the Detroit Medical Center Hospitals and in five other cities. . . . A team of five specialists from Henry Ford Hospital and a professor from Harvard University have been awarded a four-year, $340,000 federal grant to continue studies of hereditary medullary cancer of the thyroid gland. Three physicians are part of that team, and they are: **Robert A. Norum, MD; Angelos A. Kambouris, MD;** and **Gary B. Talpos, MD.** . . . **J.C. Rosenberg, MD, PhD,** and **Robert D. Allaben, MD,** both of the WSU School of Medicine, were named to the board of trustees of the Transplantation Society of Michigan recently. . . . **Robert Schindler, MD,** immediate past president of the Berrien County Medical Society, is the president-elect of the 5,000-member Christian Medical Society. He will take office in Boston in May. . . . New chairman of the Henry Ford Hospital Council is **Bruce W. Steinhauer, MD.** The Council is the governing body of the hospital's medical and surgical staff. . . . **William J. Jones, MD,** Allen Park, is the new president of the Civil Aviation Medical Association. . . . **Edward E. Vivirski, MD,** Jackson, was featured in an extensive article in the *Jackson Citizen Patriot* recently. Doctor Vivirski, 71, has served a large population of Polish-speaking patients in the same office since 1939. . . . **William H. Beierwaltes, MD,** chief of the Division of Nuclear Medicine at the U-M Hospitals, received the Hevesy Nuclear Medicine Pioneer Award from the Society of Nuclear Medicine. He pioneered the use of radioactive compounds to locate and treat various forms of cancer, and made several other milestone contributions to medicine.

Ms. Greenhoe is editorial secretary to *Michigan Medicine.*

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Insulin Therapy in the 1980s
Lois Jovanovic, MD, Associate Director, Clinical Research Center, Assistant Professor of Medicine, Cornell University School of Medicine

Oral Hypoglycemic Agents in the 1980s
Aaron Vinik, MD, Professor of Internal Medicine and Surgery, Division of Endocrinology, University of Michigan

Insulin Delivery Systems: Today's Means and Tomorrow's Prospects
David Schade, MD, Associate Professor of Medicine, Division of Endocrinology and Metabolism, University of New Mexico

Pregnancy and Diabetes
Boyd E. Metzger, MD, Assistant Program Director, Center for Endrocrinology, Metabolism and Nutrition, Professor of Medicine, Northwestern University School of Medicine

Defects in Insulin Receptors in Diabetes Mellitus
Jesse Roth, MD, Chief, Diabetes Branch, National Institute of Arthritis, Diabetes, Digestive and Kidney Diseases, National Institutes of Health

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Denis Daneman, MD, Assistant Professor of Pediatrics, Hospital for Sick Children

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CATEGORY I COURSES

***Michigan Medicine* each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517)337-1351.

Date: March 26-27, Rheumatology Seminar. Location: Sheraton-Southfield Hotel, Southfield. **Sponsor:** Wayne State University School of Medicine, Division of Rheumatology. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 4201 St. Antoine, 4H UHC, Detroit, 48201 (313) 577-1180. **Approved for:** 9.5 hours of Category I Credit.

Date: March 30, Third Annual Day in Adolescent Medicine. Location: St. Lawrence Hospital, Lansing. **Sponsors:** Michigan State University College of Human Medicine, Michigan Academy of Family Practice and Central Michigan Pediatric Society. **Contact:** Noreen Chapman, Administrative Offices, St. Lawrence Hospital, 517/377-0555. **Approved for:** 6 hours of Category I credit.

Date: March 30, Selected Topics in Oral Cavity Carcinoma — A Practical Approach. Location: Sheraton-Southfield Hotel, Southfield. **Sponsor:** Wayne State University School of Medicine, Department of Otolaryngology. **For:** Dental hygienists, dentists, family practitioners, and internists. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 4201 St. Antoine, 4H UHC, Detroit, 48201 (313) 577-1180. **Approved for:** 7.25 hours of Category I Credit.

Date: April 7-8, 4th Annual Pulmonary Rehabilitation Symposium. Location: Kalamazoo Center Hilton Inn. **Sponsor:** Southwestern Michigan Area Health Education Center and Borgess Medical Center, Pulmonary Services Department. **Cost:** Both Days - $95; One Day - $75. **Contact:** Charles L. Zeller, Jr., MD, Director, Continuing Medical Education, SMAHEC, 1521 Gull Road, Kalamazoo 49001, (616) 388-7877. **Approved for:** 9.5 hours of Category I Credit.

Date: April 8-10, Tutorial on Myofascial Release Technique. Location: Kellogg Center for Continuing Education, MSU, East Lansing. **Sponsor:** MSU Colleges of Osteopathic Medicine and Human Medicine. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48824 (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: April 13, "Current Neurology: Diagnosis and Treatment." Location: Borgess Auditorium. **Sponsor:** Southwestern Michigan Area Health Education Center and Borgess Medical Center. **Cost:** $85. **Contact:** William Daam, Director, Neurophysiology Dept., 1521 Gull Road, Kalamazoo 49001. **Approved for:** 6 hours of Category I Credit, and 6 prescribed hours by the Academy of Family Physicians.

Date: April 13, Spring Symposium 1983: Selected Short Subjects in Anatomic Pathology. Location: Towsley Center, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education. **Cost:** $105 for practicing physicians, $85 for physicians-in-training. **Contact:** Office of CME, The Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: April 14-16, Second Annual Spring Workshop — Neonatal ECMO. Location: The Towsley Center, Ann Arbor. **Sponsor:** U-M Medical School, The Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, and The Departments of Surgery and Pediatrics. **For:** Neonatologists, pediatric surgeons, cardiac surgeons, perfusionists, and others involved in or planning to develop an ECMO team. **Cost:** $245. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 20 hours of Category I Credit.

Date: April 15, Dilemmas in the Care of Critically Ill and the Dying Patient; Ethical and Legal Perspectives. Location: Stouffer's Battle Creek Hotel. **Sponsors:** Battle Creek Area Medical Education Corporation, Community Hospital of Battle Creek and Leila Hospital and Health Center. **Cost:** $30. **Contact:** BAMEC, 632 North Avenue, Battle Creek 49017, (616) 963-3791. **Approved for:** 7 hours of Category I Credit.

Date: April 15-17, Tutorial on Myofascial Release Technique. Location: Kellogg Center (MSU), East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: April 15-17, Spring Symposium in Radiation Oncology. Location: U-M Medical Center, Ann Arbor. **Sponsor:** U-M Medical School, Office of Continuing Medical Education, Dept of Postgraduate Medicine and Health Professions Education, and The Dept of Radiation Therapy. **For:** Radiation oncologists, oncologists, radiation therapy technologists, and nurses and physicians involved in the treatment of cancer patients. **Cost:** $295. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 19 hours of Category I Credit.

Date: April 16, Medical Consequences of Nuclear Weapons and Nuclear War. Location: Civic Center, Lansing. **Sponsors:** MSU Colleges of Human and Osteopathic Medicine, Michigan Nurses Association, Michigan Department of Public Health, Ingham County Board of Health, E.W. Sparrow Hospital and Michigan Health Officers Association. **Contact:** Continuing Medical Education, E.W. Sparrow Hospital, Box 30480, Lansing, 48909. **Approved for:** 5 hours of Category I credit.

Date: April 20, Computers in Obstetrics, Gynecology, and Neonatology. Location: Zuckerman Auditorium, Detroit. **Sponsor:** Sinai Hospital. **Cost:** $75 - physicians. **Contact:** Edward Lichten, MD, Dept. Obstetrics/Gynecology, Sinai Hospital, 6767 W. Outer Dr., Detroit 48235, (313) 493-6060. **Approved for:** 6 hours of Category I Credit.

Date: April 20, Pediatric Acute Care. Location: Saint John Hospital, 22101 Moross Rd., Detroit 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Pediatric. **Cost:** Physicians $90; Residents, fellows, nurses, allied health professionals, and others $35. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education, (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: April 21, Workshop on Acid-Base Disorders: A Practical Approach for the Clinician. Location: Gilmore Center for Health Education, Kalamazoo. **Sponsors:** Southwestern Michigan Area Health Education Center, and Bronson Nephrology. **Cost:** $80. **Contact:** Charles L. Zeller, Jr., MD, Director, Continuing Medical Education, SMAHEC, Stryker Center, 4th Floor, 1521 Gull Road, Kalamazoo 49001, (616) 388-7877. **Approved for:** 8 hours of Category I Credit.

Date: April 21-22, Perinatology for the Practicing Physician — The Low Birth Weight Infant. Location: Sinai Hospital Department of OB/GYN. **Sponsor:** Mothers and Infants Centers, Sinai Hospital of Detroit. **For:** Obstetricians, perinatologists, pediatricians, neonatologists, nurses. **Cost:** $100. **Contact:** John W. Goldkrand, MD, Sinai Hospital of Detroit, 6767 W. Outer Drive, Detroit 48235, (313) 493-6060. **Approved for:** 12 hours of Category I Credit.

Date: April 23, Diabetes: Current Concepts, 1983. Location: South Macomb Hospital, Warren. **Sponsor:** Detroit-Macomb Hospital Corporation. **For:** Internists, endocrinologists, pediatricians, obstetricians, family practitioners and other interested physicians. **Cost:** $60. **Contact:** Detroit-Macomb Hospital Corporation, Department of Medical Affairs, 7815 E. Jefferson, Detroit 48214, (313) 821-6000, ext. 270. **Approved for:** 7 hours of Category I Credit.

Date: April 25-26, 54th Annual Spring Conference Ophthalmology Cataract, Aphakia and Myopia — Medical and Surgical Management. Location: The Towsley Center, Ann Arbor.

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Sponsor: U-M Medical School, Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education and The Department of Ophthalmology. **Cost:** $295. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 12 hours of Category I Credit.

Date: April 25-29, Advanced Muscle Energy Tutorial (Below Diaphragm). Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: April 26, Infectious Diseases Symposium. Location: East Auditorium, Butterworth Hospital, Grand Rapids. **Sponsor:** Butterworth Hospital Medical Education. **Cost:** $40. **Contact:** Erwin J. Haas, MD, Program Director, Butterworth Hospital, 100 Michigan, NE, Grand Rapids, 49503, (616) 774-1835. **Approved for:** 8 hours of Category I Credit.

Date: April 27, Operative Obstetrics II: A Case-oriented Approach. Location: The Towsley Center, Ann Arbor. **Sponsor:** The U-M Medical School, The Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, and The Department of Obstetrics and Gynecology. **For:** Obstetricians, family practitioners, general practitioners, pediatricians, and other health care professionals concerned with care of the obstetric patient. **Cost:** $115. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 6 hours of Category I Credit.

Date: April 29, "Clinical Aspects of Sports Medicine." Location: Western Michigan University. **Sponsors:** Southwestern Michigan Area Health Education Center, and Borgess Hospital. **Cost:** $75. **Contact:** Charles L. Zeller, Jr., MD, Director, Continuing Medical Education, SMAHEC, 1521 Gull Road, Kalamazoo 49001, (616) 388-7877. **Approved for:** 7 hours of Category I Credit.

Date: April 30-May 1, International Conference: Empirical Approaches to the Validation of Manipulation. Location: MSU College of Osteopathic Medicine, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **For:** DOs, MDs, physical therapists and others concerned with the effects of manipulative therapy upon back pain. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 14.5 hours of Category I Credit.

Date: May 11, "Dealing with Common Emotional Disorders." Location: Gilmore Center for Health Education, Kalamazoo. **Sponsors:** Southwestern Michigan Health Education Center, and The Upjohn Company. **Cost:** $50. **Contact:** Charles L. Zeller, Jr., MD, Director, Continuing Medical Education, SMAHEC, 1521 Gull road, Kalamazoo 49001, (616) 388-7877. **Approved for:** 7 hours of Category I Credit.

Date: May 12-13, Phlebotomy Team: Third Annual Spring Conference. Location: The Towsley Center, Ann Arbor. **Sponsor:** U-M Medical School, Office of Continuing Medical Education, Dept of Postgraduate Medicine and Health Professions Education, and Phlebotomy Services Department of Pathology. **Cost:** $175. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 10 hours of Category I Credit.

Date: May 13-15, Michigan Society of Pathologists' May Seminar. Location: Bay Valley Inn, Bay City. **Sponsor:** Michigan Society of Pathologists. **Contact:** Dr. Willys F. Mueller, Department of Pathology, Hurley Hospital, Flint. **Approved for:** 3 hours of Category I Credit.

Date: May 18, Inflammatory Bowel Disease. Location: Saint John Hospital, 22101 Moross Rd., Detroit 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Surgery. **Cost:** Physicians $90; Residents, fellows, nurses, allied health professionals, and others $35. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education, (313) 343-4877. **Approved for:** 8 hours of Category I Credit.

Date: May 20, 13th Annual Cardiology Symposium. Location: Borgess Medical Center. **Sponsors:** Southwestern Michigan Area Health Education Center, and Borgess Medical Center. **Cost:** $85. **Contact:** Charles L. Zeller, Jr., MD, Director, Continuing Medical Education, SMAHEC, 1521 Gull Road, Kalamazoo 49001, (616) 388-7877. **Approved for:** 7 hours of Category I Credit.

Date: May 23-25, Clinical Chemistry and Immunology 5th Annual Spring Conference. Location: The Towsley Center, Ann Arbor. **Sponsor:** U-M Medical School, The Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, and The Department of Pathology. **Cost:** $245. **Contact:** Office of Continuing Medical Education, The Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 18.5 hours of Category I Credit.

Date: May 23-27, Head and Neck Oncology. Location: U-M Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School, The

Continued on page 201

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MEETINGS

MSMS, MSMS/A, AMA, and medical assistants

March 23 — MSMS Conference for Women Physicians, Michigan Inn, Southfield, contact: Sherry Fent, 517/337-1351.

April 6 & 7 — Michigan Conference on Maternal & Perinatal Health, Grand Center, Grand Rapids, contact: Katie Brewbaker, MSMS headquarters.

April 21-24 — Medical Assistants State Annual Convention, Plymouth Hilton, Plymouth, contact: Caroline Rich, MSMS headquarters, 517/337-1351.

April 29-May 1 — MSMS House of Delegates, Hyatt Regency, Dearborn, contact: Richard Campau, 517/337-1351.

May 2-3-4 — MSMS/A 57th Annual Convention, Sheraton Inn, Jackson, contact: Caroline Rich, 517/337-1351.

May 26-27 — Annual Gull Lake Conference, MSMS Committee on Maternal and Perinatal Health, MSU Conference Center, Gull Lake, Kalamazoo, contact: Katie Brewbaker, MSMS headquarters, 517/337-1351.

June 18-23 — Annual Meeting of the AMA House of Delegates, Marriott Hotel, Chicago, contact: Bruce Ambrose, MSMS headquarters.

June 19-22 — AMA Auxiliary Convention, The Drake Hotel, Chicago, IL, contact: Caroline Rich, 517/337-1351.

July 21-24 — MSMS Council Midsummer Meeting, Deer Lake, Boyne Mountain, contact: Warren F. Tryloff, MSMS headquarters.

Sept. 14 — MSMS Council Meeting (Rescheduled from Sept. 21 to Sept. 14), MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Oct. 27 — MSMS Leadership Conference, Long's Convention Center, Lansing, contact: William Madigan or Kevin Kelly, MSMS headquarters, 517/337-1351.

Nov. 15-17 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters, 517/337-1351.

Nov. 23 — MSMS Council, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Other Meetings

March 20-24 — 1983 Annual Meeting, National Association of School Psychologists, Westin Hotel, Detroit, contact: Sharon Pelty, PO Box 55, Southfield, 48037 (313) 851-3229.

April 20-24 — 1983 Annual Meeting, Society for Research in Child Development, Cadillac Hotel, Detroit, contact: Dorothy H. Eichorn, Tolman Hall, University of California, Berkely, CA 94720, (415) 642-6401.

April 23-26 — 1983 Annual Meeting, Michigan Dental Association, The Westin Hotel, Detroit, contact: Gerri Matelske, 230 N. Washington, Lansing, 48933, (517) 372-9070.

May 19-21 — 1983 Annual Meeting, Michigan Association of Osteopathic Physicians and Surgeons, Inc., Dearborn, contact: D. A. "Tony" Deshaw, 33100 Freedom Rd., PO Box 286, Farmington, 48024, (313) 476-2800.

May 26 — Southwestern Michigan Perinatal Association "Perinatal Potpourri," Western Michigan University, Kalamazoo, contact: Karen Riley, RN, OB Education Coordinator, Memorial Hospital, 2611 Morton Ave., St. Joseph 49085, 616/983-8171.

May 26-31 — American Association for the Advancement of Science, Westin Hotel, Detroit, contact: Ms. Elisabeth Zeutschel, 1101 Vermont Ave. NW, Washington, DC 20005 or Ph: (202) 842-9530.

June 4-7 — 1983 Annual Meeting, Michigan Optometric Association, Boyne Highlands Inn, Harbor Springs, contact: William D. Dansby, Fifth Floor Capitol Bldg., 115 W. Allegan St., Lansing, 48933, (517) 482-0616.

June 5-9 — 1983 Annual Meeting, American Society of Hospital Pharmacists, Cobo Hall, Detroit, contact: Marilyn Sullivan, 4630 Montgomery Ave., Bethesda, MD 20814 (301) 657-3000.

June 22-24 — 1983 Annual Meeting, Michigan Licensed Practical Nurses Association, Amway Grand Plaza, Grand Rapids, contact: Barbara Wells, 5900 Executive Dr., Lansing, 48910, (517) 882-6657.

August 7-11 — 1983 Annual Meeting, National Pharmaceutical Association, Westin Hotel, Detroit, contact: James N. Tyson, PO Box 934, Howard University, Washington, DC 20059 or Ph: (202) 636-7963.

Sept. 6-10 — Association for the Advancement of Medical Instrumentation (AAMI) 1983 Regional Meeting, Detroit, interested participants/cosponsors for 1983 or 1984 meetings should contact: Renee Pietrangelo, AAMI national office, 703/525-4890.

Oct. 6-9 — 1983 Annual Meeting, National Black Nurses Association, Westin Hotel, Detroit, contact: E. Lorraine Baugh, PO Box 18358, Boston, MA 02118 or Ph: (617) 266-9703.

Oct. 10-14 — 1983 Annual Meeting, National Mental Health Association, Hyatt Regency Dearborn, contact: Molly Mannon, 1800 N. Kent St., Arlington, VA 22209 or Ph: (703) 528-6405.

Nov. 10-12 — Michigan Association for Health, Physical Education, Recreation & Dance, Hilton Inn, Traverse City, contact: Sanford Dornbos, Eastern Michigan University, Ypsilanti, 48197, (313) 487-0175.

Nov. 11 — 1983 Annual Meeting, American Medical Women's Association, Dearborn, contact: Carol Meyers, 465 Grand St., New York, NY 10002 or Ph: (212) 533-5104.

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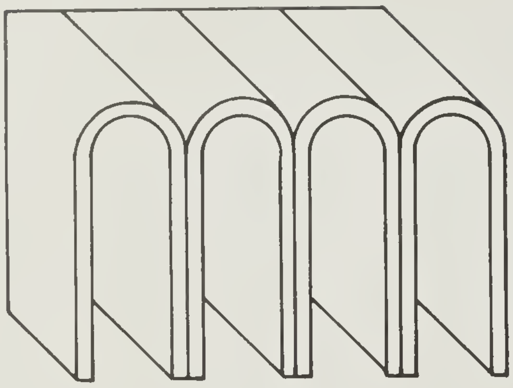
DEATHS



Thomas H. Bottomley, Jr., MD
Port Huron

Thomas H. Bottomley, Jr., MD, Port Huron, died December 6. He was 66. Doctor Bottomley was a graduate of Dennison University and Case Western Reserve Medical School in Cleveland. He practiced in the Port Huron area for 35 years, and was affiliated with Port Huron General and Mercy hospitals. Doctor Bottomley was active in several local civic and social organizations.

Carl Dahlgren, MD
Bloomfield Hills

Carl Dahlgren, MD, Bloomfield Hills, died January 15. He was 84. Doctor Dahlgren practiced in the Oakland County area for 50 years. He earned his undergraduate degree at Alma College, where he was captain of the basketball team, and graduated from the Detroit College of Medicine and Surgery in 1926. Doctor Dahlgren was on the staff of St. Joseph General Hospital in Pontiac before his 1975 retirement, and was a World War I Navy veteran.

James A. Devlin, MD
Midland

James A. Devlin, MD, Midland, died December 6, 1982 at the age of 58. He earned his undergraduate degree in Ireland, then completed his MD degree at the University of Michigan in 1955. Doctor Devlin was instrumental in the founding of the Irish American Orthopaedic Society, and served as its president in 1978. He was a past president of the Michigan Orthopaedic Society, and a member of the Detroit Academy of Orthopaedic Surgery, the C.L. Mitchell Orthopaedic Society and the World Medical Association. He was a diplomate of the American Board of Orthopaedic Surgery and a Fellow of the American Academy of Orthopaedic Surgery, the American College of Surgeons and the Pan American Medical Association.

Arlington F. Lecklider, MD
Grosse Pointe

Arlington F. Lecklider, MD, Grosse Pointe, died December 30. He was 92. Doctor Lecklider earned his MD degree at the University of Illinois in 1914. He was the general medical director of Fisher Body Division of General Motors for 35 years, and director of the division's personnel department for 15 years. Doctor Lecklider was the former Director of the Detroit Committee on Alcoholism, and a member of the Industrial Medical Association on both the state and national levels.

William G. McEvitt, MD
Detroit

William G. McEvitt, MD, Detroit, died January 5, at the age of 73. Doctor McEvitt retired in 1977, and was emeritus chief of plastic surgery for Harper-Grace Hospitals in Detroit. He established the cleft palate clinic at Children's Hospital of Michigan, and was an adjunct professor in the Speech, Communication, Theater and Journalism Department at Wayne State University.

William B. Steel, MD
Detroit

William B. Steel, MD, Detroit, died January 7. He was a nationally recognized radiologist. A native of Scotland, Doctor Steel emigrated to the US in 1954, and in 1959 was made a diplomate of the American Board of Radiology. He was vice-chairman of the Department of Radiology for Hutzel Hospital of Detroit at the time of his death. Doctor Steel served on the advisory committee of the American Institute of Ultrasound in Medicine, and was a member of the American College of Radiology and the Radiological Society of North America.

Morton M. Hochman, MD
Southfield

Morton M. Hochman, MD, Southfield general practitioner, died December 27. He was 81. A native of the Soviet Union, Doctor Hochman was a Detroit-area physician for more than 40 years. He earned his medical degree in 1934 from the Detroit College of Medicine (now Wayne State University). He was on the staff of Grace Hospital until his retirement in 1978, and donated his medical services to a Detroit free clinic for many years.

Murray M. Klimchuk, MD
Grosse Pointe Farms

Murray M. Klimchuk, MD, Grosse Pointe Farms, died January 4 at the age of 53. Doctor Klimchuk spent his undergraduate years at the University of Saskatchewan, then pursued his MD at the University of Toronto. He graduated in 1953. Doctor Klimchuk, an obstetrician/gynecologist, was affiliated with St. John and Evangelical Deaconess hospitals in Detroit, and Cottage Hospital of Grosse Pointe.

CATEGORY I/*Continued*

Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, and The Department of Otolaryngology — Head and Neck Surgery. **Cost:** $750. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 43 hours of Category I Credit.

Date: June 13-17, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Medicine, MSU, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine, Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48823 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: June 15, Geriatrics and Family Practice, Medical and Ethical Decision Making. Location: Saint John Hospital, 22101 Moross Rd., Detroit 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Family Practice. **Cost:** Physicians $90; Residents, fellows, nurses, allied health professionals, and others $35. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education, (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: June 16-17, Clinical Laboratory Computers: Symposium 1983. Location: U-M, The Towsley Center, Ann Arbor. **Sponsor:** U-M Medical School, The Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, and the Department of Pathology. **Cost:** $245. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 12 hours of Category I Credit.

Date: June 16, 17 and 18, Medicolegal Investigation of Death. Location: Hotel Pontchartrain, Detroit. **Sponsor:** Wayne State University School of Medicine, Department of Pathology and Wayne County Medical Examiner's Office. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 4201 St. Antoine, 4H UHC, Detroit 48201, (313) 577-1180. **For:** Medical examiners, pathologists engaged in medicolegal work, coroners, and other interested individuals. **Approved for:** 19 hours of Category I Credit.

Date: June 21-23, Real-time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Dept. of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: July 10-13, Intermediate Course on Craniosacral Technique. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: July 18-19, Developing, Marketing, and Managing Conferences: Making It In Tough Times. Location: The Towsley Center, Ann Arbor. **Sponsor:** The University of Michigan Medical School, The Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education. **For:** Those who will develop/manage conferences and need to know how to do it more effectively and economically, whether for universities, hospitals, professional societies, businesses, or hotels. **Cost:** $345. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 12.5 hours of Category I Credit.

Date: August 15-19, Tutorial on Direct Action Thrusting. Location: MSU Kellogg Center, East Lansing. **Sponsor: MSU College of Osteopathic Medicine. Contact:** Sandra Kilbourn, MA, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: September 12-16, Basic Muscle Energy Tutorial. Location: Kellogg Center (MSU), East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Sept. 29-Oct. 2, Sixth Annual Course in Diagnostic Ultrasound. Location: The Towsley Center, U-M Medical School, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **Contact:** Office of Continuing Medical Education, Towsley Center Box 057, University of Michigan Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 24 hours of Category I Credit.

Date: Sept. 30-Oct. 2, Tutorial on Myofascial Release Technique. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

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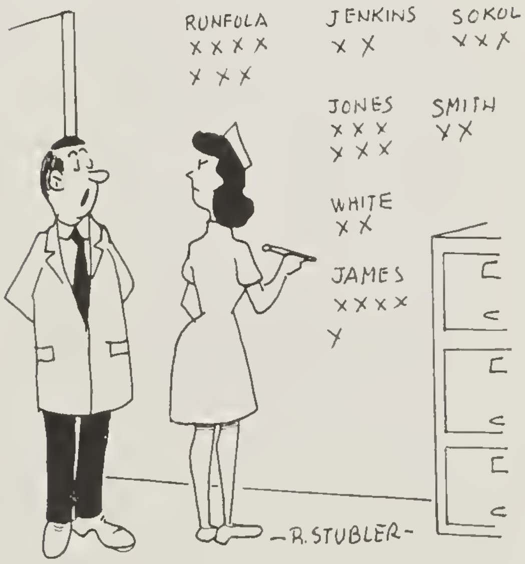

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PRESIDENT'S PAGE

Speaking of the Speaker

By Gerald H. Mandell, MD
Detroit

Doctor Mandell is speaker of the MSMS House of Delegates, a pathologist, and a long-time MSMS delegate.

The long tradition of the Speaker of the House undoubtedly is rooted in the history of man as an organized being. It probably originated even before recorded history in the role of the tribal chieftain.

The responsibility today is not much different. Tradition and rules of order have formalized the speaker's position into one of organized leadership. Today's speaker of MSMS is not so much a "leader," however, as the catalyst for running the business of the House of Delegates.

The House of Delegates is the controlling force of MSMS. This strength derives from our Constitution and Bylaws that define membership and delegate representation. Physician government truly begins at the grass roots of the county medical society, expressing itself in our annual meeting by resolution and representation. Because the House meets only annually, the executive work of the society is vested in the Council, a body of delegates represented by one physician for every 500 members. The speaker is the direct representative of the House, nominated and elected by the House and owing allegiance only to the House.

Responsibilities

I, as speaker, know that my responsibilities are always to the delegate body as a whole. They include guiding the House in its deliberations; assuring an orderly and fair exchange of ideas and debate; representing the House and its policies at the Council; promoting the policies of the House throughout the year; speaking for the membership and helping to formulate policy when urgent action is required.

Thus, the speaker must be conversant with political, social and ethical issues that are the grist for medical politics. Most issues are not difficult to support, but some evoke strong feelings and require consensus rather than arbitrary stances. Fortunately, I find that it is not the speaker's personal feelings that decide issues; rather it is the wisdom of the delegates who, though individualistic, almost always arrive at reasonable and workable solutions.

"Let the House decide" is a truism that I learned early in my studies of English and American history. The lesson was repeated at every annual meeting of MSMS that I attended, starting with Blodgett and ending with Fryfogle.

I had mixed emotions when I was courted by David Siegel, MD (who was about to become the speaker) to be his vice-speaker for the 1981 annual meeting. Although I had been active in many county and state committees, I never considered myself a politician; nor had I purposely sought office. I knew well the ethical precept about self-aggrandizement, and I was aware that others were equally or better prepared for the job.

I work diligently to develop the virtues I believe are crucial to the office of speaker: the ability to examine issues critically, to focus on the problem at hand, to express myself with some semblance of logic and to have a prejudiced point of view favoring patients and physicians. Beneath the surface I derive personal pleasure from our interactions as human beings, and I take pride in our ability to work together.

Advocates

Striving for consensus does not mean that we as a society should not take partisan stands. We properly consider ourselves major advocates of public and personal health. We are committed to a society which is physically, mentally and emotionally strong. We believe in a capable educational system and the need for individuals to develop self-responsibility.

We speak for the public good, and many of us actively participate in public affairs. We are concerned with the problems of aging, access to medical care, costs of medical care, the rationing of care, abuses of the reimbursement system, the quality of life, high technology, medicolegal liability, prenatal care, poverty, a plethora of physicians, the disabled physician and the drug culture. Underlying these issues is an ethical code that is more forceful in medicine than in any other profession.

The business of the House would bankrupt itself quickly if our members became complacent. Our strength as a medical society is assured if we continue to believe in our profession strongly enough to make a commitment for action in the public behalf.

I personally regret my too-early ascendancy to the speaker's position because of the untimely death of Dave Siegel. His loss was a tragedy for us all. Dave did bequeath us his forceful personality and a style to emulate. He is not forgotten.

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References: **1.** Kales A *et al. J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **4.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **5.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Kales JD: *Pharmacol Physicians 4*:1-6, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*:25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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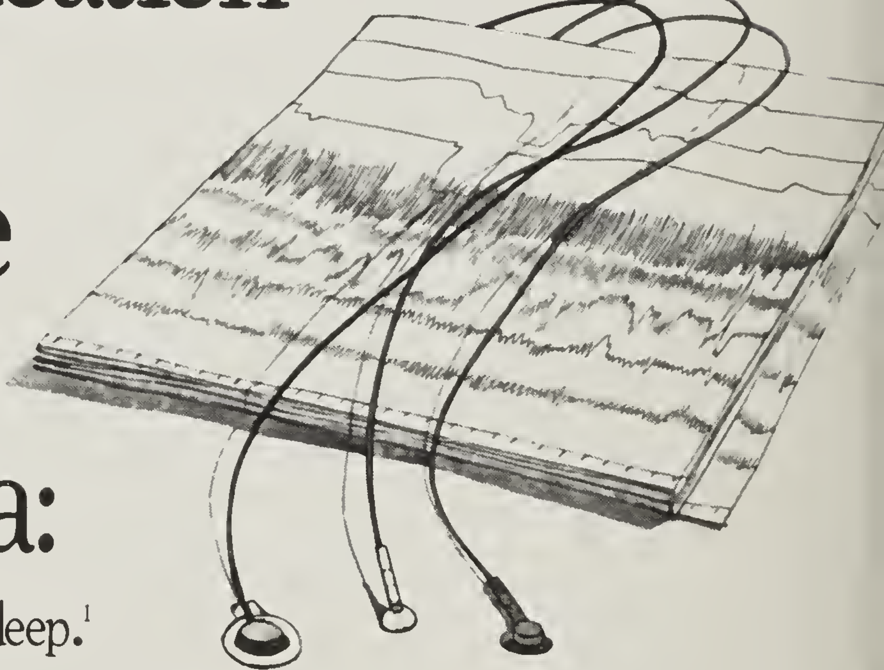

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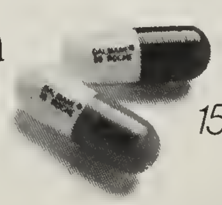

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Vol. 82, No. 14 March 17, 1983

Breaking News for Michigan Doctors

MICHIGAN MEDICINE

MEDIGRAM

MSMS DELEGATES SHOULD PLAN NOW FOR ANNUAL MEETING

It's time for MSMS delegates and alternates to make arrangements to attend the 1983 House of Delegates Meeting April 29-May 1 at the Hyatt Regency Dearborn. Housing reservation forms and invitations to the President's banquet and Michigan Doctors Political Action Committee luncheon were mailed from MSMS March 11. Delegates and alternates have until April 8 to return the housing reservation forms, and until April 21 to buy banquet and luncheon tickets.

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The deadline for MSMS members to submit resolutions for House consideration is March 30. Schedules are being set for Councilor District Briefings, when MSMS councilors will meet with members in every area of the state to discuss the resolutions submitted and the major issues of medical practice today. For further details on the House of Delegates meeting, contact Richard Campau at MSMS headquarters.

MSMS OFFERS NEW SEMINAR SERIES ON ECONOMICS

With this issue, Michigan physicians may begin signing up for the new MSMS seminar series, "Challenge of the 80s--Improving your practice in today's economic climate." Full information, as well as program and registration form appear on pages 2 and 3 inside. For details contact Mert Scholten at MSMS headquarters.

WAYNE COUNTY MDs LEARN HOW TO COMPETE

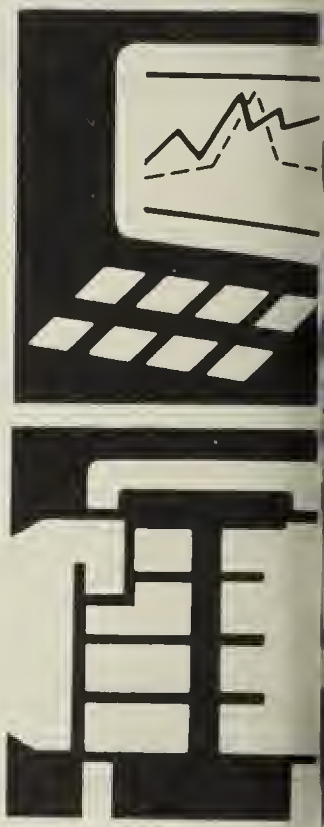
"The bottom line," said moderator Ralph Cash, MD, "is what is going to happen to each of us over the next few years." His pointed remark closed the March 8 general Wayne County Medical Society meeting on competition in the practice of medicine. The second in a two-part series sponsored by WCMS on the subject, the meeting drew 350 MDs to Holy Cross Hospital, Detroit. Speakers suggested physicians meet their public and private competition by adjusting to new, lower income levels; by cooperating with colleagues, hospitals and other health care professionals to market their services; by listening to patients, making themselves more available to patients, improving the quality of their services and providing more information to patients. Speakers were Edward F. Hughes, MD, director, Center of Health Services and Policy Research, Northwestern University; Karen Zupko, director, AMA Department of Practice Management, and MD negotiations consultant Jerry P. Clousson, JD, LLM, Chicago.

MSMS SETS SUMMER DATES FOR TEFRA SEMINARS

Revised regulations will take effect May 31 affecting payment for physicians' services in hospitals under the new Tax Equity and Fiscal Responsibility Act. The MSMS Bureau of Economics is planning two half-day seminars in Detroit and Grand Rapids in July on the impact of TEFRA upon physicians. Also on the program will be discussion of new DRG reimbursement mechanisms.

Improving YOUR Practice in

A Practical Workshop for MSMS Members



Economic recovery is slow. Money is scarce. Budgets are tight. Competition for the health care dollar is stiffening. More doctors and more ancillary health care personnel are entering the picture. What's the physician of today supposed to do? Can you survive in today's climate?

To help MSMS members withstand the challenges confronting medicine today, the Michigan State Medical Society is offering you the opportunity to attend a seminar/workshop "Improving Your Practice in Today's Competitive Climate."

To be offered six times in various locations around the state, this day-long workshop will present the information and tools you'll need to become a more successful practice manager and competitor as you face the months and years ahead.

This seminar/workshop is an extremely practical one. Theory and philosophy and hand-wringing are not part of this program. The emphasis is on practical application of workable ideas and approaches to help you hold the line on costs and discover ways of maintaining and building your practice.

Please use the registration form on the facing page to register now for the seminar location of your choice. Because of space limitations in the various facilities we have indicated with a number in parentheses the maximum number of registrants to be accepted for the location.

If there is sufficient demand for this seminar beyond the dates and locations here listed, MSMS will develop and plan further programs later in the year.

Workshop Program

Maintaining and Building Your Practice — Tips and ideas you can use to attract and hold patients. How to keep your patients happy. How to increase your practice's visibility.

Computers in Medical Practice — How to determine whether I need a computer? Questions to ask about computers. Should I lease or buy? What about using a service bureau? Dealing effectively with the computer salesperson.

Efficient Practice Management — Discover where your cash-flow problems may lie. Find out how much or how little staff you may need for improved efficiency. Learn tips on patient scheduling. Decide whether to lease or purchase your equipment.

Marketing in Medicine — Learn the difference between marketing and advertising. Find out how to develop YOUR marketing plan. Planning for change in the health system. Need patients? — how to make networking work for you.

oday's Competitive Climate

Business Decisions in Medical Practice — What type of employment policies do I need? How can I best manage my debt service? What about liability and business insurance plans?

Office Communications — Improving patient communications. Using office staff for effective communications. Handling the phone efficiently. Developing a patient information handbook. Making the office communicate.

These topics and more are on the agenda for a packed day of learning. You'll hear from experts in practice management, computers, marketing, communications and personnel administration. Expertise is drawn from business, academics, outside consultants and from MSMS' own staff resources.

Every participant will receive a notebook filled with outlines, hints, helps and action ideas as well as a copy of "Challenge of the 80s", MSMS' new 128-page book covering practice management, professional competition, communication and ethical/legal considerations.

The registration fee of $55 (for non-members, $95) includes all materials, luncheon, and breaks.

Seminar Sites and Dates

April 13	Kalamazoo Sheraton Inn (80)
April 21	Lansing, Midway Motor Lodge (90)
April 27	Flint Hyatt Regency (100)
May 18	Southfield Michigan Inn (100)
May 25	Grand Rapids Marriott Inn (100)
June 1	Ann Arbor Holiday Inn West Bank (80)

Yes, I want to attend the "Improving Your Practice in Today's Competitive Climate" Seminar/Workshop. Enclosed is my check for $55 ($95 for non-MSMS members). Please enroll me for the seminar I've indicated. (All registrations will be acknowledged and a map, address, and phone number for the facility will be provided to enrollees.)

Name ____________________

Address ____________________

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City ____________________ Zip Code __________

Medical Specialty ____________________

Save a seat for me in the following seminar: (please mark choice)

_____ 4/13 Kalamazoo _____ 4/21 Lansing _____ 5/18 Southfield

_____ 5/25 Grand Rapids _____ 6/1 Ann Arbor

MSMS MEETING ON HOSPITAL REIMBURSEMENT LEVELS

At this writing, the Department of Social Services' Medical Services Administration had called representatives of MSMS, the Michigan Hospital Association and Michigan Association of Osteopathic Physicians and Surgeons to a meeting March 15 at Henry For Hospital. The subject was the impact of current fee-for-servic reimbursement levels on hospital outpatient facilities. Hospitals have been experiencing shortfalls in payments since implementation of the MHA's Alternative Medicaid Payment System (AMPS), with its MSMS-supported provision that reimbursements t hospitals not include facilities' fees. Indeed, instead of the anticipated $7 million savings, the state finds it has saved $2 million in Medicaid reimbursements since implementation of AMPS in November.

MSMS MEMBERS VISIT LANSING POLITICAL SCENE

Continuing the work of the MSMS Physician Legislative Network, several Michigan MDs have spent time at the Capitol in recent days. On March 15, John L. Loomis, MD, River Rouge, was to lunch with Rep. Matthew McNeely, and later to attend a fund-raiser for Rep. McNeely, who is speaker pro tempore and chairman o the House Insurance Committee. On March 17, Floyd S. Tukel, MD Dearborn, was to meet with Sen. Jack Faxon and Rep. Maxine Berman, and sit in on meetings of the House Public Health and Senate Judiciary committees. In addition, Lars. W. Kleppe, MD, Petoskey, Kenneth Rowe, MD, Calumet, and Ian D. Wilson, MD, Petoskey, attended a recent fund raiser for new Senate Appropriations Committee member Sen. Mitch Irwin.

CAPSULES

Sister Agnes Mary Mansour, director, Michigan Department of Social Services, has rescinded the restrictive policy on limited Medicaid coverage of cephalosporin drugs which went into effect Feb. 1 as a Medicaid cost control measure. Policies for limite coverage of potassium supplements will remain in effect. Bulletins announcing the change will be mailed soon by the Medical Services Administration to all physicians....Members of the MSM Committee on Humanitarian Services urge all Michigan physicians to check the box on their 1983 federal income tax forms to allo a $2 donation for child abuse prevention. Funds collected from the check-off will be placed in a Children's Trust Fund within Michigan's Department of Treasury.

MEDIGRAM

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Vol. 82, No. 15 March 24, 1983
Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

600 MDs FACE REVOKED LICENSES, LOSS OF REVENUE

Approximately 600 physicians holding Michigan licenses are to receive notice of license revocation as of April 1, because they have failed to renew their licenses. While many of these physicians live in other states and may be letting their licenses expire deliberately, the Michigan Board of Medicine is concerned that perhaps a third of the doctors facing loss of their licenses simply may not have been reached by renewal notices.

The board reminds all physicians, especially those who have moved since their last license renewal, to check the expiration date in their certificates. If it is 1982 and the license has not been renewed, it is probable the renewal notices have not reached the license holders. The law provides for the license to be revoked if not renewed. All third party payers, including Blue Cross Blue Shield of Michigan and Medicaid, will stop payments to these physicians once they receive official notice of license revocation from the board. MSMS, likewise, is forced to drop these physicians from membership.

The MSMS Committee on Membership Recruitment and Retention is sending a letter to those members about to lose their licenses as a special service to help them avoid problems. MSMS also is inviting non-members to join at the same time.

MSMS LEADERS PLUGGING IN TO TELENET

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Posted: Mon  Mar 21, 1983   8:06 PM EST   Msg: KGEF-1539-2884
From:   D.CRANDALL
To:     E.POTASH
Subj:   DKC to D.Farougi
```

Following the above format, MSMS President-elect Donald K. Crandall, MD, sent his schedule to MSMS this week from his GTE Telenet terminal in Muskegon. Doctor Crandall is one of approximately 30 MSMS leaders who have the terminals in their offices now, with installation and training provided by MSMS staff. By early April, all MSMS councilors and officers should have the terminals in their offices, enabling them to take advantage of the Medmail service for MSMS action messages, and to plug into the disease and drug information retrieval systems developed by the AMA and the GTE Telenet system. MSMS leaders, after piloting the system, may recommend that the state society serve as the distributor for all Michigan physicians. Details are available from Ellen Vinocur Potash and Wayne Burmeister at MSMS headquarters.

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INSIDE THIS ISSUE

The second opportunity for MSMS members to register for the 1983 Michigan Conference on Maternal and Perinatal Health appears with this issue of Medigram. The conference is scheduled April 6-7 at the Grand Center, Grand Rapids. Register today!

HOUSE OF DELEGATES PLANNING CONTINUES WITH DISTRICT BRIEFINGS

Planning for the 1983 MSMS House of Delegates annual meeting April 29-May 1 continues, with scheduling completed for the councilor district briefings around the state. At these local sessions, MSMS councilors, delegates, alternates and staff discuss the major issues of the coming meeting. Resolutions submitted to date are reviewed, and interested members are welcome to attend and address the issues. Following is the schedule:

April 13	Districts 3 and 4, 6:30 pm, Beacon Club, Kalamazoo
	District 11, 6 pm, Century Club, Muskegon
	District 15, 6 pm, Kingsley Inn, Bloomfield Hills
April 14	District 2, 6 pm, Long's Convention Center, Lansing
	Districts 8 and 10, 6:30 pm, Bay Valley Inn, Bay City
	District 14, 6 pm, Sheraton University Inn, Ann Arbor
April 20	District 5, 6 pm, Peninsula Club, Grand Rapids
	District 7, 6 pm, Fogcutter Restaurant, Port Huron
April 21	District 9, 6 pm, Park Place Motor Inn, Traverse City
April 26	District 6, 6 pm, Flint City Club, Flint
April 29	Districts 12 and 13, 3 pm, Hyatt Regency Dearborn

SHCC DEBATES CAPITAL CAP

The Statewide Health Coordinating Council has decided to study further the controversial capital cap issue before deciding whether to support the concept. The issue occupied more than two hours of debate at the March 17 SHCC meeting. The capital cap is a concept to limit the dollar amount of projects to be built under the certificate of need program as a cost containment measure. The SHCC members decided they need more time to explore the consequences of implementation of capital caps, although the legislature probably will consider capital cap legislation in the near future.

HEALTH COSTS CONCERN BUSINESS ALLIANCE

The new Economic Alliance for Michigan has created a health committee charged with reviewing health policy consistent with the alliance's goals. The coalition was formed by the top private business and labor leaders throughout Michigan to enhance the state's business environment and make it more competitive. A primary goal of the Health Committee is to probe the cost to business of health care in the state. Also on their agenda are discussions of enabling legislation for preferred provider organizations, stimulating HMO development, and hospital capital expenditures caps. Cochairing the committee are Robert E. Dewar, chairman of the board of K-Mart Corporation, and Don Ephlin, vice president of the UAW. The committee is staffed on a part-time basis by Solomon Axelrod, MD, on loan from the University of Michigan School of Public Health.

MOST HOSPITALS HAVE PHYSICIANS ON BOARDS

Over 80 percent of Michigan hospitals answering a January MSMS survey reported that they have physicians on their boards of directors. The survey, conducted by the MSMS Medical Staff Relations Committee, also revealed that 42 percent of the responding hospitals require physicians to carry malpractice insurance to have staff privileges, and that 24 percent of the hospitals answering the survey have at least one satellite clinic.

Here is the Maternal Health Conference program and registration form

April 6-7, 1983
Grand Center, Grand Rapids

As an organization accredited for continuing medical education, the Michigan State Medical Society designates this continuing medical activity as meeting the criteria for 13 credit hours in Category I of the CME requirements of the Michigan Board of Medicine. The program has been reviewed and is accepted for 11 Prescribed credits by the American Academy of Family Physicians. Approval is pending with the Michigan Nurses Association for CEU Credit for nurses.

Wednesday morning, April 6

8:30 a.m. "Diagnosis of Sexually Transmitted Diseases in Pregnancy" — David Charles, MD, professor and chairman, Department of Ob-Gyn, Marshall University School of Medicine, Huntington, WV

9:05 a.m. "Diagnosis of the Septic Newborn" — William L. Meadow, MD, assistant professor, Neonatology and Infectious Diseases, Department of Pediatrics, University of Chicago

10:10 a.m. "Management of Sexually Transmitted Diseases in Pregnancy" — David Charles, MD

10:45 a.m. "Management of the Septic Newborn" — William L. Meadow, MD

Noon luncheon meetings

"Regionalized Perinatal Care"
"Antepartum Fetal Monitoring"
"Certified Nurse Midwifery"
"Apnea Monitoring"

Wednesday afternoon, April 6

1:45 p.m. "Ob-Gyn: Responding to Public Demands" — Robert M. Kretzschmar, MD, professor and chairman, Department of Ob-Gyn, University of Missouri-Kansas City

2:30 p.m. "The Status of Bonding — 1983" — Marshall H. Klaus, MD, chairman, Department of Pediatrics, MSU College of Human Medicine, East Lansing

3:45 p.m. "Potential Role of Patient Values and Preferences in Clinical Decision Making" — Marilyn L. Rothert, RN, PhD, director, Lifelong Education, College of Nursing

Thursday morning, April 7

8:30 a.m. "Sexuality and the Pregnant Patient" — Robert M. Kretzschmar, MD

9:15 a.m. "Obstetric Disability: An Employer's Perspective" — Kenneth E. Olthoff, general director, Worldwide Employee Benefits, Personnel Administration and Development Staff, General Motors Corporation

10:30 a.m. "Advising Pregnant Women About Exercise" — Mona M. Shangold, MD, assistant professor of Ob-Gyn, director of Sports Gynecology Center, New York Hospital/Cornell Medical Center

Noon luncheon meetings

"Intrapartum Fetal Monitoring"
"Drugs and Pregnancy"
"Certified Nurse Midwifery"
"The Role of the Referring Hospital in Perinatal Transport"

Thursday afternoon, April 7

1:45 p.m. "The Very Low Birth Weight Fetus" — Federico G. Mariona, MD, director, obstetrics and maternal/fetal medicine, Hutzel Hospital/WSU Perinatal Center, Detroit

2:15 p.m. "The Very Low Birth Weight Neonate" — Leonard L. Radecki, MD, co-director, Gerber Neonatal Intensive Care Unit, Butterworth Hospital, Grand Rapids

2:45 p.m. "Ethical Issues in the Treatment of Low Birth Weight Babies" — Howard Brody, MD, assistant professor, family practice and philosophy and assistant coordinator, Medical Humanities Program, MSU College of Human Medicine

3:15 p.m. "Legal Pitfalls in the Treatment of Low Birth Weight Babies" — David J. Cooper, JD, senior partner, Garan, Lucow, Miller, Seward, Cooper, and Becker, PC, Detroit

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Advance Registration

Please complete and mail to Michigan Conference on Maternal & Perinatal Health, Box 950, East Lansing 48823

	Wednesday			
	Physician	**Nurse**	**Other**	**Student/ House Officer**
☐ Morning & Afternoon General Sessions	$25	$15	$15	No Charge
☐ Luncheon Meetings (limited to 35 people, indicate 1st & 2nd choices)				
__ Regionalization	$ 8	$ 8	$ 8	$ 8
__ Antepartum Monitoring	8	8	8	8
__ Midwifery	8	8	8	8
__ Apnea Monitoring	8	8	8	8
Wednesday total	$____	$____	$____	$____

	Thursday			
	Physician	**Nurse**	**Other**	**Student/ House Officer**
☐ Morning & Afternoon General Sessions	$25	$15	$15	No Charge
☐ Luncheon Meetings (limited to 35 people, indicate 1st & 2nd choices)				
__ Intrapartum Monit.	$ 8	$ 8	$ 8	$ 8
__ Drugs & Pregnancy	8	8	8	8
__ Midwifery (repeat)	8	8	8	8
__ Perinatal Transport	8	8	8	8
Thursday total	$____	$____	$____	$____

Name ______________________________
Address ______________________________
City ______________ Zip ______________ Phone ______________

Wednesday Total $ ________
Thursday Total ________
GRAND TOTAL $ ________

Checks payable to
Michigan State
Medical Society

CORRECTION

An item in the March 17 issue of Medigram contained some incorrect information regarding the issue of Medicaid fee-for-service reimbursement to hospital outpatient facilities. Here is a correct synopsis of the situation:

The issue of Medicaid fee-for-service reimbursement to hospital outpatient facilities remained controversial throughout the year. Originally proposed as part of the Physician Primary Sponsor Plan (PPSP) on a demonstration basis in Wayne County, the fee-for-service reimbursement policy was extended statewide by an April executive order to become effective September 1. The Michigan Hospital Association filed a lawsuit against implementation of the policy and also proposed an Alternative Medicaid Payment System in the legislature which, among other things, would rescind the fee-for-service reimbursement policy. MSMS and MHA subsequently concurred that the policy would be applied to free-standing satellite clinics if the AMPS proposal secured legislative approval. The AMPS proposal did not pass and the MHA lawsuit was dismissed. Discussions continue throughout the state as to the economic impact on hospitals of Medicaid fee-for-service payment for outpatient services.

CAPSULES

The dates are May 18 and 19 for the MSMS Bureau of Economics' half-day seminars in Detroit and Lansing on the impact of the new Tax Equity and Fiscal Responsibility Act (TEFRA) upon individual MDs' practices. The seminars were announced in the March 17 Medigram. Also on the program will be discussion of new diagnosis-related group (DRG) reimbursement mechanisms.... The MSMS Physician Legislative Network participant for this week is William C. Sharp, MD, Detroit. Doctor Sharp is scheduled to meet with Sen. Jackie Vaughn and be the senator's guest on the Senate floor, as well as monior a House of Representatives session....MSMS members who want the best available information on conducting a successful medical practice in today's competitive climate are invited to attend a series of six practical workshops planned during April, May and June by MSMS in locations around the state. The dates, facilities and programs of the seminars are described in the March 17 Medigram. Interested members may register now for the seminars using the form appearing in that issue. Details are available from Mert Scholten at MSMS headquarters.

MEDIGRAM

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Vol. 82, No. 16 March 31, 1983
Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

TEFRA TOPIC OF MSMS EVENTS

The sweeping Tax Equity and Fiscal Responsibility Act (TEFRA) and its impact upon physicians' practices is the topic of several coming MSMS events. On April 30, during the MSMS House of Delegates meeting at the Hyatt Regency Dearborn, a forum on TEFRA will be presented to delegates and their registered guests. Speaker will be Ronald Horwitz, PhD, professor in the Oakland University School of Economics and Management. The forum is scheduled at 1:30 PM in the Springwells Suite, following the annual MDPAC luncheon. Details are available from Richard Campau at MSMS headquarters.

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TEFRA seminars, to describe the law's ramifications to physicians, are planned May 18 and 19 in Detroit and Lansing, respectively, by the MSMS Bureau of Economics. Physicians registering for the Lansing seminar will join attendees of the MSMS Medical Staff Relations Conference, who will be meeting that day at Long's Convention Center. (See related article below.) Details of the seminars are available from John Richards at MSMS headquarters.

MSMS DUES ARE DUE

Second notices for MSMS dues payments have gone in the mail to members who are tardy in their payments. The deadline for the second and final installment payment, for those members making that arrangement, was March 10 at MSMS headquarters. MSMS Operations and Member Services Department Manager Wayne Burmeister urges members to delay no longer in making their dues payments, so as not to lose out on MSMS benefits.

MSMS MEDICAL STAFF CONFERENCE MAY 19 IN LANSING

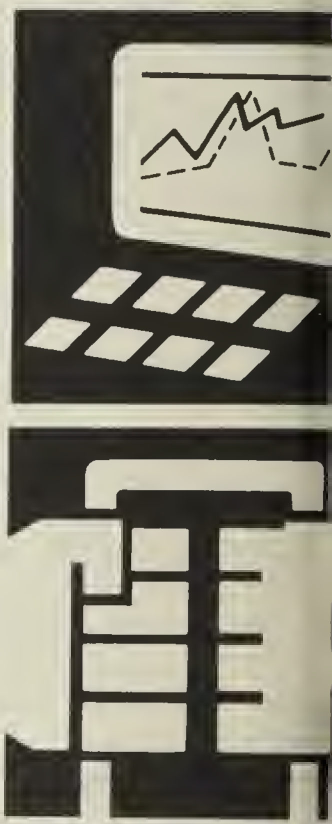
Michigan chiefs of staff and medical staff leaders are invited to the third MSMS Medical Staff Relations Conference, scheduled May 19 at Long's Convention Center, Lansing. Topics of the conference will be legal arguments for closed vs. open hospital staffs, the new TEFRA regulations and their impact upon physicians' medical practices, and the new diagnostic related group (DRG) proposals. Among the speakers will be MSMS Legal Counsel A. Stewart Kerr, Detroit. Conference chairman is Gary D. Maynard, MD, Kalamazoo, also chairman of the MSMS Committee on Medical Staff Relations. Details on the conference are available from William Madigan at MSMS headquarters.

INSIDE THIS ISSUE

Your opportunity to get the best information on managing a successful practice in today's competitive climate is yours with this issue. Inside is the registration form for the new MSMS seminars on "meeting the challenge of the 80's" planned during April and May in six locations around the state. Register now!

Improving YOUR Practice in

A Practical Workshop for MSMS Members



Economic recovery is slow. Money is scarce. Budgets are tight. Competition for the health care dollar is stiffening. More doctors and more ancillary health care personnel are entering the picture. What's the physician of today supposed to do? Can you survive in today's climate?

To help MSMS members withstand the challenges confronting medicine today, the Michigan State Medical Society is offering you the opportunity to attend a seminar/workshop "Improving Your Practice in Today's Competitive Climate."

To be offered six times in various locations around the state, this day-long workshop will present the information and tools you'll need to become a more successful practice manager and competitor as you face the months and years ahead.

This seminar/workshop is an extremely practical one. Theory and philosophy and hand-wringing are not part of this program. The emphasis is on practical application of workable ideas and approaches to help you hold the line on costs and discover ways of maintaining and building your practice.

Please use the registration form on the facing page to register now for the seminar location of your choice. Because of space limitations in the various facilities we have indicated with a number in parentheses the maximum number of registrants to be accepted for the location.

If there is sufficient demand for this seminar beyond the dates and locations here listed, MSMS will develop and plan further programs later in the year.

Workshop Program

Maintaining and Building Your Practice — Tips and ideas you can use to attract and hold patients. How to keep your patients happy. How to increase your practice's visibility.

Computers in Medical Practice — How to determine whether I need a computer? Questions to ask about computers. Should I lease or buy? What about using a service bureau? Dealing effectively with the computer salesperson.

Efficient Practice Management — Discover where your cash-flow problems may lie. Find out how much or how little staff you may need for improved efficiency. Learn tips on patient scheduling. Decide whether to lease or purchase your equipment.

Marketing in Medicine — Learn the difference between marketing and advertising. Find out how to develop YOUR marketing plan. Planning for change in the health system. Need patients? — how to make networking work for you.

oday's Competitive Climate

Business Decisions in Medical Practice — What type of employment policies do I need? How can I best manage my debt service? What about liability and business insurance plans?

Office Communications — Improving patient communications. Using office staff for effective communications. Handling the phone efficiently. Developing a patient information handbook. Making the office communicate.

These topics and more are on the agenda for a packed day of learning. You'll hear from experts in practice management, computers, marketing, communications and personnel administration. Expertise is drawn from business, academics, outside consultants and from MSMS' own staff resources.

Every participant will receive a notebook filled with outlines, hints, helps and action ideas as well as a copy of "Challenge of the 80s", MSMS' new 128-page book covering practice management, professional competition, communication and ethical/legal considerations.

The registration fee of $55 (for non-members, $95) includes all materials, luncheon, and breaks.

Seminar Sites and Dates

April 13	Kalamazoo Sheraton Inn (80)
April 21	Lansing, Midway Motor Lodge (90)
April 27	Flint Hyatt Regency (100)
May 18	Southfield Michigan Inn (100)
May 25	Grand Rapids Marriott Inn (100)
June 1	Ann Arbor Holiday Inn West Bank (80)

Yes, I want to attend the "Improving Your Practice in Today's Competitive Climate" Seminar/Workshop. Enclosed is my check for $55 ($95 for non-MSMS members). Please enroll me for the seminar I've indicated. (All registrations will be acknowledged and a map, address, and phone number for the facility will be provided to enrollees.)

Name ____________________

Address ____________________

____

City ____________________ Zip Code ________

Medical Specialty ____________________

Save a seat for me in the following seminar: (please mark choice)

____ 4/13 Kalamazoo ____ 4/21 Lansing ____ 4/27 Flint

____ 5/18 Southfield ____ 5/25 Grand Rapids ____ 6/1 Ann Arbor

DELAY POSSIBLE
IN MEDICAID PAYMENTS

Michigan physicians' Medicaid payments due to be remitted March 30 may be delayed one week, according to the Department of Social Services. Those payments will be included with the next pay cycle's remittances. The reason for the delay is that state funds for the quarter are not available to cover all practitioner and pharmacy warrants.

DOCTOR ROVNER
CHAIRS ANNUAL
SCIENTIFIC MEETING

The Planning Committee for the 1983 MSMS Annual Scientific Meeting is at work approving courses for the Nov. 15-16-17 program. The committee, chaired by David R. Rovner, MD, has reviewed 45 proposals to date from Michigan medical schools, specialty societies and individual physicians. It will announce the complete list of courses in a June issue of Medigram. Doctor Rovner, who has been on the committee for four years, is in his first year as Annual Scientific Meeting chairman.

DATA UPDATE

The MSMS Bureau of Economics reports that 1980 data reveal 58 percent of the personal health care benefit payments in Michigan are generated from the private sector, 38 percent originate from Blue Cross Blue Shield of Michigan and the remaining 20 percent from other commercial carriers. The public sector accounts for 42 percent of the personal health care benefit payments, with 24 percent reimbursed by Medicare and 18 percent by Medicaid. According to the March 21 issue of Medical Economics, that Medicare reimbursement comprises one-third of internists' incomes, as opposed to 17 percent of the typical office-based physicians' income.

CAPSULES

Reminder: MSMS delegates and alternates have until April 8 to make housing reservations for the House of Delegates meeting April 29-May 1 at the Hyatt Regency Dearborn. Details are available from Richard Campau at MSMS headquarters....Members of the MSMS Medicaid Liaison Committee plan to meet April 6 with the new director of the Michigan Department of Social Services, Sr. Agnes Mary Mansour. The meeting will be held at MSMS headquarters....Letters are going this week from MSMS President James H. Tisdel, MD, to component and specialty society presidents to give them complete information about the Federal Trade Commission's final order regarding the case of the MSMS vs. the FTC. The action is mandated in the order itself.

MEDIGRAM

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Vol. 82, No. 16 March 31, 1983

Vol. 82, No. 17 April 7, 1983
Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

PLAN TO ATTEND ONE OF THESE IMPORTANT WORKSHOPS!

"Improving Your Practice in Today's Competitive Climate"

8:15 a.m.	Registration, coffee and rolls
9:00 a.m.	**"Effective, Efficient Practice Management"** Analyzing your practice situation, staffing, collection policies, patient scheduling, etc. John Anthony, Manager, PSG, Inc.
10:45 a.m.	**"Office Communications — The Link to Patient Satisfaction"** Using medical assistants, newsletters, patient information brochures, the telephone and your office to help you communicate more effectively. Mert Scholten, MSMS Chief of Communications
11:15 a.m.	**"Computers in Medical Practice"** Learning to ask the right questions about your computer needs; leasing vs. buying; using a service bureau. John Anthony, Manager, PSG, Inc.
12:15 p.m.	Lunch
1:00 p.m.	**"Business Decisions in Medical Practice"** Personnel policies; patient records, insurance needs; legal requirements; office layout, space and decor. Vada Davis, MSMS Assistant Administrator and John Anthony, Manager, PSG, Inc.
2:00 p.m.	**"Marketing Strategies for Today"** What marketing is and isn't; developing a marketing plan; adapting to changing markets; marketing tools. Gilbert Harrell, PhD, Professor of Marketing, MSU
3:15 p.m.	**"Maintaining and Building YOUR Practice"** Positioning; increasing visibility; attracting and holding new patients; making networking work for you. Gilbert Harrell, PhD, Professor of Marketing, MSU
4:00 p.m.	**"Meeting Medicine's Challenges Today"** A hard look into the future as medicine faces problems within and without. Donald K. Crandall, MD, MSMS President-Elect

Enroll me in the seminar/workshop indicated below. Enclosed is my check for $55 ($95 for non-members) which covers registration, luncheon, breaks, and all course materials.

____ Kalamazoo (4/13)
____ Southfield (5/18)
____ Lansing (4/21)
____ Grand Rapids (5/25)
____ Flint (4/27)
____ Ann Arbor (6/1)

Name ____________________

Address ____________________

____

City ____________________ **Zip** __________

Please mail to MSMS, 120 W. Saginaw, East Lansing, MI 48823.
Registrations will be acknowledged with location map, phone number of site.

HEALTH SERVICES BEAR SHARE OF BUDGET CUTS

MSMS leaders are analyzing the impact of the Blanchard Administration's major actions to restore Michigan's financial health. On March 30, the second piece of the governor's budget-balancing package was adopted by the legislature. A $225 million executive order cutting the state budget followed on the heels of the previous week's $675 million increase in state revenues through passage of the income tax package.

Cuts to come from human services programs total $93.9 million. The executive order calls for the largest reduction, $69.5 million, to come from social services. The governor earmarked $47.1 million to come from Medicaid expenditures, "after consultation with the affected health care providers." The majority of the savings probably will come from deferred payments to hospitals.

The Department of Public Health was cut by $6.5 million. The executive order eliminates subsidies to 326 family practice residents at 23 hospitals and clinics, aid to poison control centers at Children's and Blodgett hospitals, licensing of clinical labs and consultants to local immunization programs.

Other cuts ordered are $17.9 million from mental health. Eight statutory boards and commissions are dropped from licensing and regulation. Of particular MSMS interest is elimination of the Medical Science Unit, which investigates malpractice cases, and the Drug Diversion Unit, which checks illegal drug use.

CAPSULES

Peter S. Thoms, MD, Flint will meet with Genesee County Senator Joe Conroy, and Reps. Charles Mueller and Robert Emerson April 14 in Lansing. Doctor Thoms will visit the Capitol as part of the MSMS Physician Legislative Network. ...The MSMS Bureau of Economics has learned the Department of Health and Human Services is creating an Office of Health Financing Integrity. This office will be the focal point of activities to control Medicare and Medicaid fraud and waste. HHS estimates $72 billion will be spent during the current fiscal year on the two programs. ... The Statewide Health Coordinating Council has endorsed the concept of capital caps hospital expenditure limits and encouraged the legislature to consider such legislation. Simultaneously a SHCC committee will review strategies for carrying out the capital caps concept.

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Vol. 82, No. 18 April 14, 1983

Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

LEGISLATURE TURNS TO HEALTH COSTS

Health care cost containment bills should see legislative action between now and the summer recess. This could include proposals for an annual statewide ceiling on hospital capital expenditures and legislation designed to establish a climate for preferred provider organizations. The MSMS/coalition proposal to depress professional liability costs also will be introduced during the spring session. The legislature returned April 12 following Easter recess prepared to take up 1983-84 budget proposals. Gov. Blanchard is expected to present his budget draft next week, having already achieved an increase in state income taxes and a $225 million reduction in the current budget.

MDSS TO OFFER CAPs CONTRACTS

Despite MSMS and MAOPS urgings not to, the Michigan Department of Social Services has announced its decision to offer contracts to six capitated ambulatory plans (CAPS) for Medicaid patients in the state. CAPs to be offered contracts are located in the following counties: Kalamazoo (1), Kent (2), Oakland (1) and Wayne (2). MSMS and MAOPS representatives Allen F. Turcke, MD, Susan Adelman, MD, William Anderson, DO, and Charles Murphy, DO, met with DSS Director Sister Agnes Mary Mansour March 30 to urge DSS to honor its agreement not to place CAPs in Wayne County until the Physician Primary Sponsor Plan was given sufficient developmental time. The MSMS Medicaid Liaison Committee, at its regular meeting with state officials April 6, acknowledged that the agreement not to place CAPs in Wayne County on top of the PPSP was made with previous DSS Director John Dempsey, and not with Sister Mansour. The committee questioned whether the entire relationship between MSMS and the DSS also is subject to change because of the turnover in the state's political administration. But committee members report prospects of forging new lines of communication with Sister Mansour looked encouraging after a reception in her honor concluding the April 6 meeting at MSMS headquarters.

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REP. GARY OWEN MDPAC LUNCHEON SPEAKER APRIL 30

Speaker of the Michigan House of Representatives Gary M. Owen (D-Ypsilanti) is keynote speaker for the 1983 Annual MDPAC Luncheon April 30 during the House of Delegates meeting. Speaker Owen will discuss important medical legislation slated for the 1983 session. Interested delegates may purchase tickets through House of Delegates registration packets.

INSIDE THIS ISSUE

Hospital chiefs of staff and MSMS members interested in new forms of health care delivery have opportunities to register for coming MSMS conferences inside. Registration forms on pages 2 and 3 feature an MSMS Medical Staff Relations Conference set May 19, and two seminars on the Tax Equity and Fiscal Responsibility Act (TEFRA) May 18 and 19 in Southfield and Lansing.

MICHIGAN STATE MEDICAL SOCIETY

Tax Equity Fiscal Responsibility Act of 1982 (TEFRA) and The Practicing Physician

TEFRA, SECTION 108, regulations for provider based physicians will rework the Medicare Program and have significant financial consequences for many physicians.

The MSMS Bureau of Economics is scheduling two seminars to aid physicians in understanding **TEFRA**. The seminars will be held on Wednesday, May 18 at 1:30 p.m. at the Sheraton-Southfield, Detroit and Thursday, May 19 at 1:30 p.m. at Long's Convention Center, Lansing.

The program will be a discussion of the need to change contractual relationships between hospital-based physicians and their institutions, as well as a practical discussion of how these changes will affect reimbursement for all hospital-based physicians.

Speakers will include:

Michael D. Gibson, JD, Kerr, Russell and Weber, Detroit
Thomas J. Herrmann, MD, Associate Dean of Clinical Affairs, College of Human Medicine, Michigan State University
Lawrence A. Manson, JD, Wood, Lucksinger & Epstein, Chicago
George Nicholson, CPA, Partner, Arthur Anderson Company, Inc.

Also included in the seminar will be a review on the recently enacted **DRG Prospective Reimbursement System** for Medicare and its impact.

- -

REGISTRATION

NAME______________________________ SPECIALTY________________

ADDRESS____

____

May 18 - Southfield___ May 19 - Lansing___

Registration Fee: $25 includes a specially prepared workbook and a reception following the seminar. Mail Check and Registration Form To: **TEFRA** Conference, Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48823. For more information, please contact Deborah Zannoth at 517-337-1351.

MICHIGAN STATE MEDICAL SOCIETY
MEDICAL STAFF RELATIONS CONFERENCE

May 19, 1983
Long's Convention Center
Lansing, Michigan

PROGRAM

8:30 a.m. **Registration**

9:00 **Opening Comments** - Gary D. Maynard, MD, Chairman, Medical Staff Relations Committee

9:15 **Legal Briefing on Open vs. Closed Medical Staffs** - A. Stewart Kerr, JD, MSMS Legal Counsel; J. Kay Felt, JD, Dykema, Gossett, Spencer, Goodnow & Trigg

10:30 **Questions and Answers**

Break

11:00 **Sharpening Criteria for Admission to Medical Staffs/Manpower Budgeting/ Avoiding Adversary Roles/Exclusive Contracts** - Robert W. Black, MD, Chief-of-Staff, Harper-Grace Hospitals

11:45 **Questions and Answers**

12:00 **Luncheon**

1:30 p.m. **Tax Equity Fiscal Responsibility Act of 1982 (TEFRA)**

The afternoon session will be a presentation of changes brought about by the recently enacted TEFRA regulations.

The program will be a discussion of the need to change contractual relationships between hospital-based physicians and their institutions, as well as a practical discussion of how these changes will affect reimbursement for all hospital-based physicians.

Speakers will include:
Michael D. Gibson, JD, Kerr, Russell and Weber, Detroit
Thomas J. Herrmann, MD, Associate Dean of Clinical Affairs, College of Human Medicine, Michigan State University
Lawrence A. Manson, JD, Wood, Lucksinger & Epstein, Chicago

5:00 **Reception**

- -

Registration

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Registration Fee: $25 includes luncheon (Please make check payable to Michigan State Medical Society). Mail Check and Registration Form To: Medical Staff Relations Conference, Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48823. For more information, please contact William Madigan at 517/337-1351

MSMS COMPETITION SEMINARS UNDERWAY

Registrations are coming in well for the series of six MSMS seminars on "Improving Your Practice in Today's Competitive Climate." The first of the seminars, April 13 in Kalamazoo, already will have taken place by the time you read this newsletter. The other five are scheduled April 21 in Lansing, April 2 in Flint, May 18 in Southfield, May 25 in Grand Rapids, June 1 in Ann Arbor. The seminars feature segments on office communications, practice management, computers, business decisions, marketing strategies, maintaining and building medical practices and meeting today's medical practice challenges. Registration forms and programs appear in the March 31 and April 7 Medigrams.

PREGNANCY DISABILITY DECISIONS AHEAD FOR MICHIGAN MDs

American women are taking increasingly longer pregnancy leaves from their workplaces. That was one of the considerations of 550 physicians, nurses and other health care professionals who attended the 1983 Michigan Conference on Maternal and Perinatal Health April 6-7 in Grand Rapids. Speaker Kenneth Olthoff, Detroit, emphasized that physicians are going to have to make tough decisions on the appropriate length of leave for pregnancy, with large sums of disability pay in the balance. Mr. Popular topics at the two-day meeting administrated by MSMS we those on pregnancy and exercise, sexually-transmitted diseases in pregnancy and drugs and pregnancy.

RESOLUTIONS POINT WAY FOR DELEGATES

MSMS staff are preparing final copies of appproximately 70 resolutions proposed for delegates' consideration at the 1983 MSMS House of Delegates meeting. The resolutions deal with competition, continued competency, home health care, the Board of Medicine, health care for the unemployed, bioethics, medical staff organization and other pertinent topics. The resolutions will be referred by subject to reference committees now being formed by the speaker.

MEDIGRAM

Michigan State Medical Society
120 West Saginaw Street
East Lansing, Michigan 48823

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Editor: Judith Marr

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Vol. 82, No. 18 April 14, 1983

MICHIGAN MEDICINE

April 1983 JOURNAL OF THE MICHIGAN STATE MEDICAL SOCIETY Volume 82, Number 19

ndall, M.D.
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MSMS and Auxiliary — partners

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Before delivery, **Anusol® Ointment*** rapidly, temporarily relieves the itching, burning, and pain of hemorrhoids of pregnancy and other anorectal disorders. Used concomitantly, **Tucks® Pads** add cooling, soothing comfort to tender anorectal tissues. **Tucks** also serve as a hygienic rectal wipe, gently cleansing away potentially irritating fecal residue.

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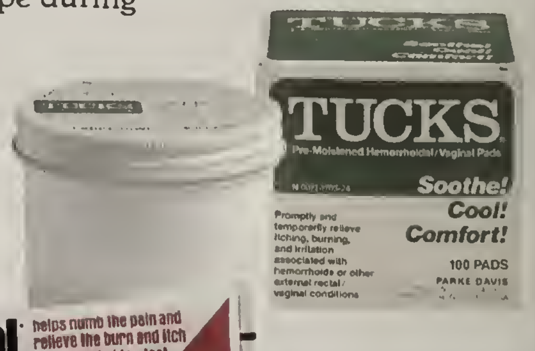
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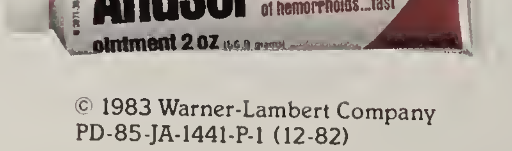
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MICHIGAN MEDICINE
MSMS and Auxiliary — partners

The close partnership possible between MSMS and its auxiliary is evidenced in the photo on this month's cover. It shows MSMS President-elect Donald K. Crandall, MD, and MSMS/Auxiliary President Cheri Calvelo in deep discussion during the Auxiliary's recent Legislative Day. The special report this month takes up the issue of the medical society's relationship with its auxiliary. **(Photo by Sheri Greenhoe)**

MICHIGAN MEDICINE

April 1983 Volume 82, Number 19

Special report

210 How well do MSMS and its auxiliary work together? What can be done to improve things? Who are the leaders of the MSMS Auxiliary and what are its major projects? This month's special report goes into depth on these subjects, bringing MSMS members closer to the organization that is potentially its nearest partner in improving the health of the state's citizens. Articles inside are by Cheri Calvelo and Charles Downs.

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Judith Marr

Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

Neither the editors nor the state medical society will accept responsibility for statements made or opinions expressed by any contributor in any article or feature published in the pages of the journal. The views expressed are those of the writer and not necessarily official positions of the society. Products and services advertised in *Michigan Medicine* are neither endorsed nor warrantied by MSMS.

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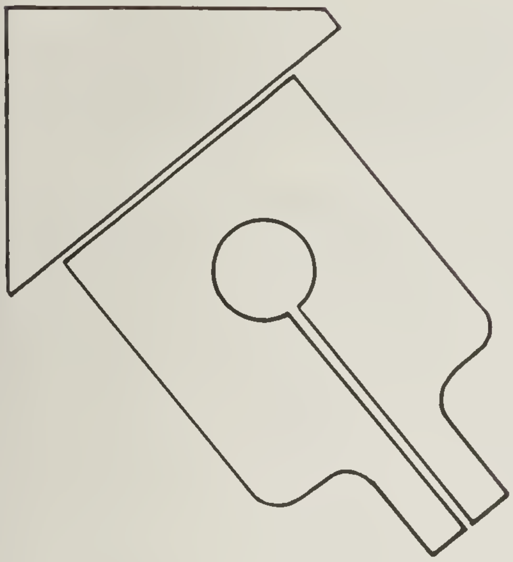
LETTERS



Family affair

It really is a family affair at MSMS. You've all got a bunch of cute kids. . .

I took the liberty of forwarding the February, 1983 issue to our maternal health care nursing professor in the School of Nursing.

Thanks for helping assure my getting *Michigan Medicine* regularly. It is a fine magazine.

Robert Manning
Northern Michigan University
Marquette

Nuclear medicine speakers bureau

The American College of Nuclear Physicians (ACNP) has established a public education program and is providing speakers — without charge — to address the subject of nuclear medicine and its surrounding nuclear waste issues.

There are two aspects of nuclear medicine which need to be addressed. First, the specialty of nuclear medicine is only 25 years old, yet increasingly is being relied upon for the diagnosis and treatment of serious diseases. One out of every two US hospital patients require a nuclear medicine test accounting for the estimated 100 million nuclear medical procedures performed each year.

Second, this medical practice generates low-level radioactive waste which must be transported and disposed of at licensed disposal sites, of which there is presently a critical shortage. According to the federal Low-Level Waste Policy Act of 1980 each state must pass legislation to either enter into a regional compact or establish its own disposal facility, by 1986, or it may have to stop the practice of nuclear medicine.

Many states are opposed to opening a nuclear disposal site due to the public's overall fear of radioactivity. If, however, the waste management problems are not solved, the benefits of nuclear medicine could be lost.

The American College of Nuclear Physicians believes it critical to educate the public on the practice of nuclear medicine and the low-level waste issues. We want to address misconceptions about nuclear medicine, the use of radioactive materials and the disposal of low-level wastes.

For further information about our Public Education Program, please contact me (202) 857-1191. I will be happy to provide you with additional information or make arrangements for you to interview one of our speakers.

Barbara C. Teele
Educational Coordinator
American College of
Nuclear Physicians
Washington, D.C.

What does it mean?

I just finished reading (without really understanding) the final order published in the Volume 82, No. 12, March 10, 1983 issue of *Michigan Medicine/Medigram.*

Who wrote it? An attorney? An aide? Good grief! I have some knowledge of prose style; I have written 24 publications including one textbook and yet, after reading part II A of this order three times I still cannot understand what it means. I have shown it to colleagues in the doctor's lounge at a local hospital. None could agree on an interpretation.

Perhaps I am one of an exceptional minority. Somehow, I doubt it. If the final order has any importance — I suppose it does since you printed it — then why not rewrite it so that the people to whom it is directed can understand it?

Edwin Vann, Ph.D., M.D.
St. Joseph

Editor's note: MSMS President James H. Tisdel, MD, responded to Doctor Vann that he also believes the FTC final order is open to considerable interpretation and is poorly written.

As we indicated in the "Medigram," the Michigan State Medical Society was required to publish the final order verbatim in the next available issues of "Medigram" and *Michigan Medicine.* What members read was the the FTC's own language.

Fortunately, we have additional space available in *Michigan Medicine* to provide for the MSMS legal counsel interpretation of the FTC final order. We hope members will better understand the interpretation as presented by the MSMS legal experts in this issue of the magazine.

Correction

The requirements for cadaver kidney donorship begin with willing next-of-kin, and include persons between the ages of *5 and 55.* The latter is emphasized by Sanford B. Izenson, MPH, renal consultant, Division of Chronic Disease Control, Michigan Department of Public Health. Mr. Izenson was co-author of an article in the February issue of *Michigan Medicine,* in which the age range was incorrectly identified.

Candidates for nutritional therapy...

10,000,000 alcoholics. Ethanol may produce many effects that together bring about nutritional deficiencies, so that alcoholism affects nutrition at many levels.[1]

25,500,000 geriatric patients. The older patient may have some disorder or socio-economic problem that can undermine good nutrition.[2]

23,500,000 surgical patients. Nutritional status can be compromised by the trauma of surgery; and some operations interfere with the ingestion, digestion and absorption of food.[3]

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5,000,000 hospital patients with infections.[4] Many are anorectic and may have a markedly reduced food intake. Supplements are often provided as a prudent measure because the vitamin status of critically ill patients cannot be readily determined.[3]

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References: 1. Shaw S, Lieber CS: Nutrition and alcoholism, chap. 40, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME. Philadelphia, Lea & Febiger, 1980, pp. 1220, 1237. 2. Watkin DM: Nutrition for the aging and the aged, chap. 28, in *Modern Nutrition in Health and Disease, op. cit.*, p. 781. 3. Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease, op. cit.*, pp. 1084, 1089, 1114. 4. Dixon RE: *Ann Intern Med 89* (Part 2): 749-753, Nov 1978. 5. Committee on Dietary Allowances, National Research Council: Recommended Dietary Allowances, ed 9. Washington, National Academy of Sciences, 1980, p. 13.

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THE MULTIVITAMIN/MINERAL FORMULATION

SPECIAL REPORT

Partners in service — the MSMS Auxiliary goal

By Charles R. Downs
East Lansing

Do you, MSMS, take this auxiliary to be your lawfully connected partner, to have and to hold, for better or for worse . . .

And do you, auxiliary, take this society . . .

To an observer listening to members of the auxiliary and of the MSMS talk about their organizational relationships, the language and tone sound much like that of husbands and wives talking about marital relationships.

By this analogy, the MSMS-auxiliary relationship is probably a good marriage, even though problems exist and need to be aired. The two groups are like a husband and wife who have lived in relative harmony for years and then, suddenly, seem neither to be quite the same person who made the wedding vows. So, wanting the marriage to stay intact, they begiin looking at ways of adapting to their "new" spouses.

Auxiliary's changed

As in many real marriages, it is the female who appears to have changed the most, to have become more aware of her identity as an individual rather than as her husband's wife, to spurn the helpmate role in favor of a full partnership, to play down the role of social planner and organizer, and to become involved in "serious" matters.

"I have changed!" says Mrs. Dottie Csonka of Essexville, who chairs the auxiliary's AMA-ERF Committee.

"Women have changed! They are a different force in the world. And what has happened to the medical society and the auxiliary is what has happened to society in the past 20 years."

James Tisdel, MD, MSMS president, agrees that the society-auxiliary relationship is changing. The auxiliary used to serve more of a social role, such as arranging parties and putting on benefits to raise funds for scholarships, he notes.

"Now, they are becoming more involved in the actual problems of society — child abuse, World Medical Relief, the legislative process — not just looking at the interests of their spouses."

Over the past three years, Doctor Tisdel points out, the auxiliary has become more integrated; members serve on society committees and attend more society meetings. Similar changes are being seen at the national level.

"The changes," according to Doctor Tisdel, "can have only a beneficial effect."

Most, but not all society members would agree that the auxiliary should become more action oriented.

MSMS forgets

Current Auxiliary President, Cheri Calvelo of Jackson agrees that relationships are improving and that having auxiliary membership on society committees has helped. Still, she adds:

"The auxiliary is a powerhouse that could be better utilized . . . Sometimes, they (MSMS members) forget we are here."

She points out that physicians are often not able to devote much time to worthy projects that benefit society as well as organized medicine, projects such as health promotion and legislative affairs, for example.

"Potentiation," she points out, is the key word — the society and the auxiliary can be much more effective than the sum of their individual efforts. Similarly, she contends, the auxiliary needs to work with other organizations to achieve effective results in such areas as campaigning for seat-belt laws.

Auxiliary President-Elect Betty Drew of Bloomfield Hills also sees improvement in relationships.

"Working together is certainly the way to go," says Mrs. Drew. Still, she adds, society members are not sufficiently aware of what the auxiliary is doing. "They have to be made more aware before they can give us more respect."

The MSMS, she illustrates, recently recognized the World Medical Relief Program by giving a humanitarian award to the director, but did not seem to realize that the Auxiliary had been an active supporter of the program for many years.

Mr. Downs is a Lansing-area free-lance writer.

Auxilians appointed to serve on MSMS committees

Advisory to the Bureau of Economics — Mrs. Lawrence Grennan (Barbara), Muskegon County.

Committee on Maternal and Perinatal Health — Mrs. A. J. Krapohl (Pat), Jackson County

Humanitarian Services — Mrs. Edgar A. Calvelo (Cheri), Jackson County; Mrs. Dale R. Drew, (Betty), Oakland County

Membership Recruitment and Retention — Mrs. Charles E. Mueller (Jane), Saginaw County

Program to Assist Impaired Physicians (Promotion Committee) — Mrs. Stephen Mason (Joyce), Washtenaw County

Public Service — Mrs. Edgar A. Calvelo (Cheri), Jackson County

MSMS and Michigan Hospital Association auxiliary members from his home district engaged Rep. Richard Fitzpatrick (D-Battle Creek) in intense discussion over lunch recently. The occasion was the 1983 MSMS Auxiliary Annual Legislative Day in Lansing.

Also in general agreement is Mrs. Lillian Fields of Parma, who chairs the auxiliary's Legislation Committee. She expresses concern, however, that there still are misunderstandings.

Too many society members, she contends, do not see auxiliary members as full partners.

"They see us as embellishing the work they are doing, rather than working with them." That, she contends, does not make for a good marriage of organizations or of man and woman. "We really do change things by working together."

Show capability

MSMS Executive Director Warren Tryloff has a slightly different viewpoint, although he welcomes the changes that have taken place and points out that having auxiliary members on committees adds a new dimension to the deliberations.

He also notes that "the Auxiliary performs valuable services in areas which the MSMS cannot or will not tackle."

However, he adds, the auxiliary is going to have to show it is capable of taking on more complicated and sophisticated projects. One of the most important steps the auxiliary can make for itself, he maintains, is to streamline its procedures for carrying out projects. The present organization structure is too cumbersome to move quickly and decisively, he explains, though current proposed bylaws changes could make a big improvement.

Mr. Tryloff also contends that the auxiliary needs to become more businesslike in its approach to money and that one of the first steps is to reexamine its dues structure.

"If dues were raised from the present $5 a year to say, $35 a year, the auxiliary would be able to afford full-time professional staff, rather than the part-time staffing now provided by MSMS," Tryloff points out.

Whatever the solutions, there seems little question that the Auxiliary faces tough problems. A major concern is a recent slip in membership, particularly in the more metropolitan counties. Membership was 2,639 in 1979 and 2,269 in 1982, reports Treasurer Darlene Smith of Muskegon. That's a drop of 14 percent.

A variety of reasons for the drop have been noted. One is that an increasing percentage of new doctors are women and that, while male spouses are fully eligible to join the auxiliary, very few have done so. Perhaps they see it as a "ladies club;" perhaps they are wrapped up in their own careers.

Similarly, many younger wives are bent on careers that they identify with more than they identify with their roles as doctors' spouses. Often, too, even wives who are carrying out more traditional homemaker roles seek an identity apart from their spouse roles and perceive the auxiliary as not contributing to that need.

Auxiliary's future

Mrs. Cavelo says she has difficulty with some of the claims about what younger women are said to feel because she perceives herself as a younger woman — at age 37, perhaps the youngest auxiliary president since its formation in 1926.

She joined the auxiliary 11 years ago and has been quite active in it and in a number of other organizations and projects. She also tends to the needs of her family.

She says her husband has been supportive of her activities just as she has been supportive of him and his profession. "Spouses really have to care about one another," she explains. "What affects him affects me."

What is the future of the auxiliary? Many members seem to be saying that they do not really want to be an "auxiliary," at least not in the New World Dictionary definition of "acting in a subsidiary, or subordinate capacity." Rather they want to be working with the society as an equal, just as they see themselves working in their marriages as equals with their spouses.

Perhaps another name, maybe "Organization of Physician Partners," would better express the sense of purpose perceived by a large segment of the auxiliary.

Even those seeking change, in the society as well as the auxiliary, look to the future with guarded optimism, based on the improvements of recent years.

Or, as Mrs. Fields put it, "I'm hopeful. I'll go along for the ride and see what happens."

Modern-day MSMS Auxiliary heads firmly in direction of service

By Cheri Calvelo
Jackson

IT'S
INVOLVEMENT
TIPS SCALES
"IT'S UP TO YOU"

MSMS/A Legislative Chairman Lillian Fields spotlights the auxiliary legislative theme.

In 1926 a group of physicians' wives met with Caroline B. Crane, MD, Kalamazoo, who served as chairman in forming a new organization, "Woman's Auxiliary to the Michigan State Medical Society."

The first formal meeting was held a year later, and Mrs. Guy L. Kiefer, Wayne County, was elected president. Although primarily social, the group soon was sponsoring home nursing courses and setting up a student loan fund for physicians' children.

The Michigan organization is one of the oldest in the nation as it was organized only four years after the AMA Auxiliary.

As the years progressed, the auxiliary provided leadership in spheres ranging from first aid classes during the war years to political awareness when government intervention in the medical field became increasingly apparent.

Our auxiliary now is known as the "Michigan State Medical Society Auxiliary," as we are an organization of physician spouses, both women and men. We are part of a federated structure working together with county and national organizations for educational and charitable purposes.

Our members (2,300) reside in 26 counties. Some of the county auxiliaries are primarily social organizations; however, every county participates in at least one service activity a year, and some county auxiliaries participate in more service activities than social. Today, the state auxiliary is primarily service oriented. Nonetheless, we recognize that social interaction and gratification are important, as we all have something in common — we are married to physicians.

Following are some of our service projects and programs.

AMA-ERF

The AMA Educational and Research Foundation provides funds for medical schools, unrestricted and for categorical research grants, scholarships, and programs to improve the quality and availability of medical care. The Medical Education Loan Guarantee Program has been temporarily suspended due to economic conditions; however, contributions still are needed to maintain loan reserves.

Recently, a new Student Assistance Fund has been established enabling a direct gift to be made to a medical student for a legitimate educational expense with disclosure of the donor.

The most popular AMA-ERF project is the "Holiday Sharing Card." This began as a county project and was adopted by the state. "The Sharing Card" wishes all a Happy Holiday by sending a card to all members of a medical society, with the names of all who have made a donation instead of individuals sending their own. The last two years the state auxiliary officers and chairmen have made donations, with their greeting being included in the December issue of the *Auxilium* (our state newsletter to all members).

State and county efforts have raised over $21,000 to date this year for AMA-ERF.

Education Committee

A vehicle was needed in 1980 to administer the newly created MSMS/A Speakers Bureau, so the Education Committee was conceived. It was formed to provide auxilians with the necessary skills to speak in their com-

Continued on page 216

Introducing MSMS Auxiliary leaders

Cheri Calvelo
Jackson
President

MSMSA president for 1982-83, Mrs. Calvelo also serves on the MSMS Committees on Humanitarian Services and Public Service. She is a sustaining member of the Michigan Doctors and American Medical political action committees and has been AMA Auxiliary delegate or alternate for the past seven years. Recently, she was appointed to serve on the Organizational Affairs Reference Committee at the AMA Auxiliary Annual Session in June 1983, and to serve on the National Health Projects Committee for 1983-84. She is a past president of the Jackson County Medical Society Auxiliary and has served this year as president of the Michigan Child Passenger Safety Association. She founded the first Child Passenger Safety Association in Jackson in 1979, which has grown into other state associations as well as a national association. She currently is active in the Michigan Coalition for Safety Belt Use representing the Auxiliary and Child Passenger Safety Association. She is a graduate of the State of New York at Buffalo with a BS in Nursing. Her husband, Edgar A., is an internist with a sub-specialty in rheumatology. They have one daughter and one son.

Betty Drew
Bloomfield Hills
President-elect

Mrs. Drew will take office as MSMS/A president in May. She is past president of the Oakland County Medical Society which she has been a member of since 1956. A registered parliamentarian, she has worked to revise bylaws for MSMS/A and other groups, and judges high school district, state and national parliamentary procedure competitions. During the past year she has reviewed job descriptions of the 28 categories of members who comprise the MSMS/A board of directors, She is the wife of Dale R. Drew, MD, Pontiac urologist.

Jane Mueller
Saginaw
Vice President

Mrs. Mueller is a former MSMS/A district director and holds positions of vice president and membership chairperson. She is past president of the Saginaw County Medical Society Auxiliary, and is current placement advisor for the Junior League of Saginaw and active in its substance abuse prevention program for grade school children and parents. She is a member of the Saginaw YMCA Board of Directors and acts as a referee with the Saginaw Swim Officials. Mrs. Mueller is a licensed practical nurse, and mother, with husband Charles E., of three children.

Helen Lechner
Grosse Pointe
Recording secretary

Mrs. Lechner is experienced in organizational work, having served as president of the Michigan Occupational Medical Auxiliary and as president of the Wayne County Medical Society Auxiliary. She presently is working as a geriatric nurse in a Grosse Pointe nursing home while earning a degree in health care administration. She also has served as a volunteer in the Bon Secours Hospital hospice program and is an American Red Cross school health aid instructor. She and husband Monroe S. Lechner, MD, Grosse Pointe occupational medicine specialist, are the parents of four sons and two girls.

More on page 214

The early years...
the middle years...
the later years...

MAKE GOOD HEALTH A HABIT
SHAPE UP FOR LIFE

Lillian Fields
Parma
Legislative Chairperson

Mrs. Fields has built on her experience as legislative chairperson and secretary of the Jackson County Medical Society/Auxiliary to serve as chairperson of the legislative activities of MSMS/A. A former seventh grade life science and third grade public school teacher, she also was named Southern Michigan Free Methodist Conference "Primary Department Superintendent of the Year" in 1975. She currently is a member of the Dahlem Environmental Education Association and is the mother of three children. She is married to Marvin Fields, MD, Jackson family physician.

Dorothy Csonka
Essexville
AMA-ERF Chairperson

A registered nurse, Dorothy "Dottie" Csonka has served as a nurse instructor for the Red Cross trained disaster management programs. She shared responsibility for establishing home meal service for the ill and elderly in Bay County. She is past president of the Bay County Medical Society Auxiliary and has been active in local hospital auxiliaries. As AMA-ERF chairperson, she does some fund-raising, processes money and forms between state and national gathering posts, encourages and helps local AMA–ERF chairpersons with their projects. She and husband Nicholas Csonka, MD, Bay City anesthesiologist, have one daughter.

Joyce A. Heyboer
Birmingham
Health Projects Chairperson

Mrs. Heyboer has been active in the MSMS Auxiliary since 1970, and has served on the state board since 1976. She has been members-at-large coordinator, District I director and recording secretary. She has worked to establish the first annual Organ Donation Awareness Week in the state. Mrs. Heyboer is past Oakland County Medical Society Auxiliary president, active in school and social activities and currently is an elder in the Presbyterian Church.

Some highlights of auxiliary history

Fifty-four years ago a group of doctors' wives met with Caroline B. Crane, MD, Kalamazoo, who served as chairman in forming a new organization, "Woman's Auxiliary to the Michigan State Medical Society." The first formal meeting was held a year later and Mrs. Guy L. Kiefer, Wayne County, was elected president. Although primarily social, the meetings were soon undertaking such projects as sponsoring home nursing courses and setting up a student loan fund for physicians' children who needed help in continuing their educations.

As the years progressed, MSMS-A provided leadership in spheres ranging from first aid classes during the war years to political awareness in 1946, when government intervention in the medical field became increasingly apparent. The Blue Cross nonprofit insurance program was considered an alternative and auxiliary members promoted this voluntary health plan.

County auxiliaries were organized into nine districts in 1948 and the state and national auxiliary worked closely with the counties in an effort to promote goals of the medical profession throughout the country.

In 1962 the American Medical Association Education and Research Foundation (AMA-ERF) was established to encourage scientific experimentation and to provide funds for the deans of the medical schools to use for an enrichment program and also a loan guarantee fund for medical students, interns and residents.

The American Medical Political Action Committee (AMPAC) was created in 1961 and three years later the Michigan Doctors Political Action Committee (MDPAC) was formed, to give organized medicine a voice in the elective process of the United States and Michigan.

The auxiliary now considers support of AMA-ERF and MDPAC among its key activities.

1979-80 was the first year of the AMA/A "Shape Up For Life" program, with special emphasis on nutrition. At the state level we became involved with stress as it related to the physician's family through the impaired physician program of MSMS and MSMS/A. The auxiliary has continued to emphasize these programs.

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency 3. Impotence due to androgenic deficiency. 4 Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely PBI may be decreased in patients taking androgens. Hypercalcemia may occur, particularly during therapy for metastatic breast carcinoma If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements Daily requirements are best administered in divided doses The following is suggested as an average daily dosage guide **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg , Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg . Postpuberal cryptorchism, 30 mg. **REFERENCE:** R B Greenblatt, M.D , R. Witherington, M D , I. B Sipahioglu, M.D. Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy*, Sept. 1976 **SUPPLIED:** 5, 10, 25 mg in bottles of 60, 250 Rx only

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REFER TO PDR

MSMS-A leads

- MSMS-A is one of the nation's oldest auxiliaries — it was organized only four years after the AMA-A.
- MSMS-A is the 10th largest state auxiliary in the nation.
- MSMS-A has had one national AMA-A president, Mrs. William Mackersie (1952-1953 State President), Wayne County.
- Mrs. Leon Parnagian, Romeo (Macomb County) served as president of the national Women's Auxiliary, Student American Medical Society.
- Mrs. Fleming Barbour (Marian), Flint, was the AMA-A Treasurer, Chairman of the Finance Committee and on the National Executive Committee.
- Mrs. Willis Dixon (Ruth) served on the AMA-A Nominating Committee in 1978-79. She has served as North Central Regional Legislative Chairman for the years 1979-80 and 1980-81. In 1981-82 she served as AMA-A Recording Secretary.
- Mrs. R. Jack Chase (Donna) served on the National Resolutions Bylaws Committee for the 1981 AMA-A Convention. She has served as the North Central Regional Health Projects Chairman.
- MSMS-A won the state category, "Award of Commendation" in the National Citation Awards Program of the Women's Conference on National Safety. The award was presented to Mrs. Edgar Calvelo, MSMS-A Chairman of Michigan Women for Highway Safety in 1980 and current president.

MSMS-A membership by counties

District I	
Huron	25
Macomb	90
Oakland	196
St. Clair	51
Wayne	212
District II	
Ingham	168
Jackson	87
Monroe	24
Washtenaw	92
District III	
Berrien	43
Calhoun	94
Kalamazoo	238
District IV	
Kent	227
Muskegon	128
Newaygo	9
Ottawa	44
District V	
Bay-Arenac Iosco	76
Genesee	252
Midland	68
Saginaw	75
Shiawassee	11
District VII	
Grand Traverse-Leelanau-Benzie	48
Wexford-Missaukee	6
District VIII	
Dickinson-Iron	20
Marquette-Alger	31
District IX	
Delta-Schoolcraft	28
Members-at-Large	
New state members	239
Total national members	2,178
Total state members	2,300

munities on such subjects as: "How to keep your medical costs down," "Shape Up for Life," "government medicine."

In 1981 the Medicare seminar was developed with participation from Michigan Blue Cross Blue Shield, the Michigan Association of Medical Assistants and Social Security Administration (local offices). The purpose is to work with local organizations to explain to Medicare recipients the terminology, deductibles, forms, repayment procedures and the process of applying for more payment than allowed.

Individual auxilians also offer services as consultants to individual counties in the areas of parliamentary procedure and management-by-objective training.

Health Projects

In 1979 the AMA Auxiliary initiated the "Make Good Health a Habit" program with a focus on nutrition, which was adopted by our state. The program was so effective that it has been continued and expanded to cover early, middle and later years.

A program of total fitness, both physical and mental, is encouraged. Good health habits such as regular exercise, good nutrition, stress management, no smoking, alochol use in moderation, and adequate rest are emphasized. Many auxilians are directly involved through teaching classes in these areas. This year our chairman has presented a series of short presentations for general county auxiliary meetings entitled "Take Five for Health!"

The national focus for 1983-84 will be "Children and Youth," under the umbrella of the Shape Up for Life Campaign, as directed by a resolution sponsored by the Michigan auxiliary. The problem of child abuse will be addressed under this focus, in cooperation with the AMA.

Another area of focus this year has been the establishment of an Annual Organ Donation Awareness Week, April 24-30 for the State of Michigan.

The MSMSA is seeking to improve public awareness and acceptance of the concept and resource of organ donation, also communicating

Continued on page 218

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to both the donor and family the "transference of life" concept rather than the ending of life. We have worked in conjunction with MSMS, the Organ Procurement Agency of Michigan, the National Kidney Foundation of Michigan, Michigan Eye Bank, and the National Institute for Burn Medicine, to prepare a pamphlet. We hope to have this distributed in physicians' offices throughout Michigan.

MSMS and MHA auxiliaries combined for the luncheon portion of the March 9 Legislative Day activities. MSMS/A President Cheri Calvelo stands here to introduce the president of the Michigan Association of Hospital Auxiliaries President Barbara Leegwater, Grand Rapids, seated to Mrs. Calvelo's left.

LANSING
CIVIC
CENTER

Speakers at the Legislative Day meeting included Carla Neuschel, lobbyist and specialty society legislation liaison from the AMA Washington office. Ms. Neuschel, right, was introduced to the crowd by MSMS/A Legislative Chairman Lillian Fields.

The Muskegon County Medical Society Auxiliary has developed a pamphlet entitled "Is He Sick?" to aid parents in determining whether or not they should send a child to school. It has been adopted by many auxiliaries throughout the country and is available to all county auxiliaries in Michigan.

Another auxiliary project for spinal screening that began iin Genesee County has been adopted by auxiliaries throughout the state and nation. The program was cited by President Reagan as an example of private sector initiatives.

Legislation

The auxiliary is a potential powerhouse that can accomplish great things through legislative action. Our Legislative Day provides the format for auxilians to become informed on legislative issues concerning the medical and health care fields. Auxilians are encouraged to get to know their legislators, with the Legislative Day luncheon providing an opportunity.

A legislative column has appeared in every issue of our state newsletter as a means to communicate with the total membership what is happening in the state and nation.

Emphasis this year has been on the Legislative Alert system. The Legislative Alert network is a valuable and efficient communication system, developed by the auxiliary in conjunction with the medical society, to trigger action on health-related legislation. The auxiliary never initiates an alert, but rather responds to requests by either the AMA (for federal legislation) or MSMS (for state legislation). Essentially, the structure of the system is that of a pyramid. Action may be via letter, telephone, telegram or a personal visit to the legislator/legislators.

Auxilians responded to an AMA Legislative Alert on efforts regarding Federal Trade Commission reform, and an MSMS Legislative Alert on the mandatory seat belt use law this year.

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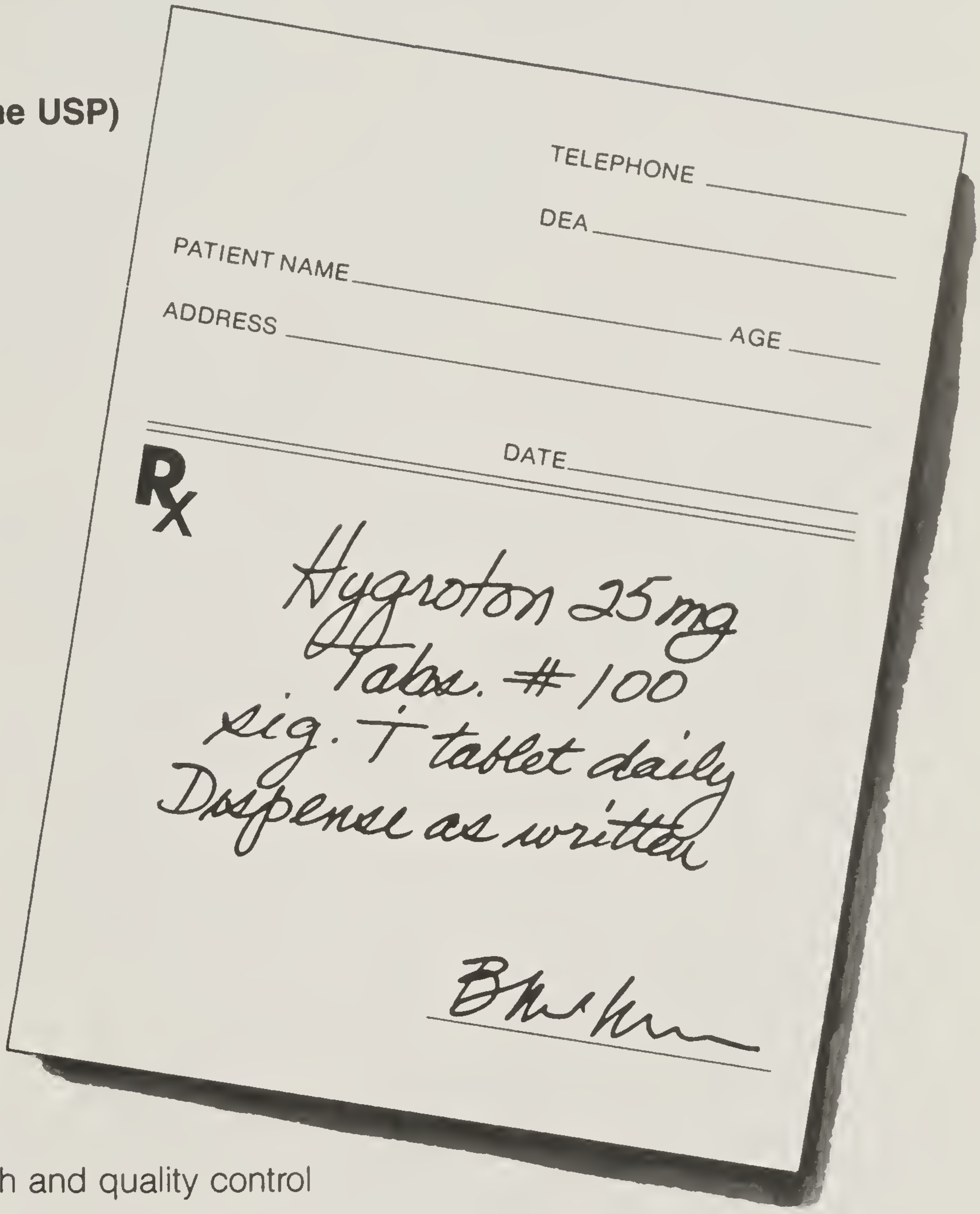

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BRIEF SUMMARY

Indications: Hypertension, adjunctive therapy in edema.

Contraindications: Anuria, hypersensitivity to chlorthalidone or other sulfonamide-derived drugs.

Warnings: Should be used with caution in severe renal disease, impaired hepatic function or progressive liver disease. May add to or potentiate the action of other antihypertensive drugs. Sensitivity reactions may occur in patients with a history of allergy or bronchial asthma. There is a possibility of exacerbation or activation of systemic lupus erythematosus with thiazides, which are related to chlorthalidone. This has not been reported with chlorthalidone. Thiazides cross the placental barrier and appear in cord blood. Use in pregnant women requires that the anticipated benefits of the drug be weighed against possible hazards to the fetus. These hazards include fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. In nursing mothers, thiazides cross the placental barrier and appear in breast milk. If use of the drug is essential, the patient should stop nursing.

Precautions: Periodic determination of serum electrolytes to detect possible electrolyte imbalance should be performed at appropriate intervals. All patients receiving chlorthalidone should be observed for clinical signs of fluid or electrolyte imbalance; namely, hyponatremia, hypochloremic alkalosis, and hypokalemia. Serum and urine electrolyte determinations are particularly important when the patient is vomiting excessively or receiving parenteral fluids. Medication such as digitalis may also influence serum electrolytes. Hypokalemia may develop with chlorthalidone as with any other potent diuretic, especially with brisk diuresis, when severe cirrhosis is present, or during concomitant use of corticosteroids or ACTH. Interference with adequate oral electrolyte intake will also contribute to hypokalemia. Digitalis therapy may exaggerate metabolic effects of hypokalemia especially with reference to myocardial activity. Any chloride deficit is generally mild and usually does not require specific treatment except under extraordinary circumstances (as in liver disease or renal disease). Dilutional hyponatremia may occur in edematous patients in hot weather. Hyperuricemia may occur or gout be precipitated in certain patients. Insulin requirements in diabetic patients may be increased, decreased, or unchanged and latent diabetes mellitus may become manifest. Chlorthalidone and related drugs may increase the responsiveness to tubocurarine. The antihypertensive effects of the drug may be enhanced in the postsympathectomy patient. Chlorthalidone and related drugs may decrease arterial responsiveness to norepinephrine. If progressive renal impairment becomes evident, as indicated by a rising nonprotein nitrogen or blood urea nitrogen, a careful reappraisal of therapy is necessary with consideration given to withholding or discontinuing diuretic therapy. Chlorthalidone and related drugs may decrease serum PBI levels without signs of thyroid disturbance.

Adverse Reactions: Anorexia, gastric irritation, nausea, vomiting, cramping, diarrhea, constipation, jaundice (intrahepatic cholestatic jaundice), pancreatitis; dizziness, vertigo, paresthesias, headache, xanthopsia; leukopenia, agranulocytosis, thrombocytopenia, aplastic anemia; purpura, photosensitivity, rash, urticaria, necrotizing angiitis (vasculitis) (cutaneous vasculitis), Lyell's syndrome (toxic epidermal necrolysis). Orthostatic hypotension may occur and may be aggravated by alcohol, barbiturates or narcotics. Other adverse reactions include hyperglycemia, glycosuria, hyperuricemia, muscle spasm, weakness, restlessness, impotence. Whenever adverse reactions are moderate or severe, chlorthalidone dosage should be reduced or therapy withdrawn.

Usual Dose: One tablet daily.

How Supplied: Tablets—100 mg. (white, scored), 50 mg (aqua) in bottles of 100, 1000 and 5000; 25 mg. (peach) in bottles of 100 and 1000; unit-dose blister packs, boxes of 100 (10 x 10 strips).

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MSMS legislative package seeks to alleviate malpractice costs

AVOIDING
A NEW CRISIS
IN MEDICAL
PROFESSIONAL
LIABILITY

In the March, 1983 issue of *Michigan Medicine* MSMS members read of the new five part legislative bill MSMS is backing to alleviate the medical malpractice situation and help control costs. A definitive booklet going to all the state's legislators this month as the legislation is introduced contains the following open letter from MSMS President James H. Tisdel, MD, Port Huron. Copies of the booklet, pictured above, are available from William Madigan at MSMS headquarters.

Increasing costs of medical care are of great concern to physicians and their patients. In presenting the information and recommendations in this document, the Michigan State Medical Society is guided by principles set forth in the association's Official Policy Manual:

1. MSMS and its individual members share with the public a concern for the proper distribution, delivery and utilization of health care;

2. MSMS has an enduring commitment to the delivery of health care in the most cost-effective manner;

3. MSMS believes that physicians have a moral and civic obligation to inform, advise, or assist third parties in deliberations concerning the quality of health care, its utilization and its cost.

As we review the last decade and look at the situation today, we find that the primary contributor to rising health care costs is inflation. All costs of living rise with spiraling inflation; but especially affected are health care sciences and medical technology.

Michigan physicians through the Michigan State Medical Society have instituted programs designed to cut overhead in office operations and patient services without reducing the quality of care.

We are keenly aware of our individual and collective responsibility to help patients avoid unnecessary costs and we are constantly seeking ways to do so. We believe voluntary actions taken by the medical profession are a check-rein on health care costs. But only a small percentage of savings can be effected through initiatives of the medical profession alone.

If cost containment is to be achieved in some areas, legislation is required to amend statutes already on the books or to establish laws relating to health care which benefit the general public but are not within the authority of the profession itself to implement. Professional liability is one such area.

Several bills dealing with liability and malpractice insurance, adopted by the legislature in 1975, have now been tested. Benefitting from this experience and the results of litigation and court decisions, we are proposing legislation this year which will refine and strengthen these statutes.

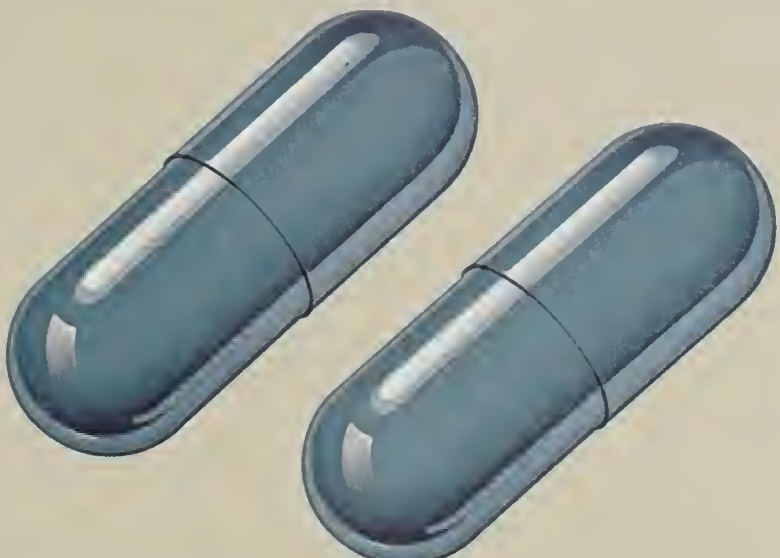
We are seeking solutions which will resolve today's problems and will produce in the future a stable environment for health care in Michigan. Serious difficulties are plaguing many states, notably New York, Florida and California, where precautionary measures were delayed too long.

Liability insurance premiums rose sharply in Michigan during the mid-70s and are a major factor in the cost of physicians' services. Our proposed legislation will enhance equity and justice in awards resulting from medical injuries, and should moderate the rising cost of malpractice litigation, settlements and premiums which ultimately are borne by health care recipients.

It is unusual for the medical society to seek legislative action on health insurance issues; but times change, problems change, perceptions change. The alternatives are ominous for patients and physicians alike as the cost of medical services and health insurance advance to new highs, and liability premiums rise to meet multi-million dollar claims.

With our positive self-help action programs and five legislative proposals, we are hoping Michigan can avoid the liability crisis that is accelerating health care costs in other states.

We respectfully submit this document for your consideration in the 1983 legislative session. Members and staff of the medical society will be available to discuss with legislative committees the concerns and proposals presented herein.



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INDICATIONS AND USAGE: These preparations are indicated for the treatment of infections caused by susceptible strains of designated microorganisms as follows: Respiratory Tract Infections (e.g., tonsillitis, pharyngitis, and lobar pneumonia) due to *S. pneumoniae* (formerly *D. pneumoniae)* and group A beta-hemolytic streptococci [penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever; Velosef (Cephradine, Squibb) is generally effective in the eradication of streptococci from the nasopharynx; substantial data establishing the efficacy of Velosef in the subsequent prevention of rheumatic fever are not available at present]; Otitis Media due to group A beta-hemolytic streptococci, *H. influenzae,* staphylococci, and *S. pneumoniae;* Skin and Skin Structures Infections due to staphylococci and beta-hemolytic streptococci; Urinary Tract Infections, including prostatitis, due to *E. coli, P. mirabilis, Klebsiella* species, and enterococci *(S. faecalis).*

Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS: *Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use).* In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephradine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro.* Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis

produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

Diuretics (potent "loop diuretics," e.g., furosemide and ethacrynic acid) — Enhanced possibility for renal toxicity.

Probenecid — Increased and prolonged blood levels of cephalosporins, resulting in increased risk of nephrotoxicity.

Drug/Laboratory Test Interactions: After treatment with cephradine, a false-positive reaction for glucose in the urine may occur with Benedict's solution, Fehling's solution, or with Clinitest® tablets, but not with enzyme-based tests such as Clinistix® and Tes-Tape®. False-positive Coombs test results may occur in newborns whose mothers received a cephalosporin prior to delivery. Cephalosporins have been reported to cause false-positive reactions in tests for urinary proteins which use sulfosalicylic acid, false elevations of urinary 17-ketosteroid values, and prolonged prothrombin times.

Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy: Teratogenic Effects/Impairment of Fertility — Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

ADVERSE REACTIONS: Untoward reactions are limited essentially to G.I. disturbances and, on occasion, to hypersensitivity phenomena. The latter are more likely to occur in persons who have previously demonstrated hypersensitivity and those with a history of allergy, asthma, hay fever, or urticaria.

(continued on next page)

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(continued)

The following adverse reactions have been reported following use of cephradine: G.I. — Symptoms of pseudomembranous colitis can appear during antibiotic therapy; nausea and vomiting have been reported rarely. Skin and Hypersensitivity Reactions — mild urticaria or skin rash, pruritus, joint pains. Blood — mild transient eosinophilia, leukopenia and neutropenia. Liver — transient mild rise of SGOT, SGPT, and total bilirubin with no evidence of hepatocellular damage. Renal — transitory rises in BUN have been observed in some patients treated with cephalosporins; their frequency increases in patients over 50 years old. In adults for whom serum creatinine determinations were performed, the rise in BUN was not accompanied by a rise in serum creatinine. Others — dizziness, tightness in the chest, and candidal vaginitis.

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Children over 9 months of age — 25 to 50 mg/kg/day in equally divided doses q. 6 or 12 h. For otitis media due to *H. influenzae:* 75 to 100 mg/kg/day in equally divided doses q. 6 or 12 h but not to exceed 4 g/day. Dosage for children should not exceed dosage recommended for adults. There are no adequate data available on efficacy of b.i.d. regimens in children under 9 months of age.

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Scientific and Educational Affairs committee offers these AMA scientific reports

The MSMS Council's Reference Committee on Scientific and Educational Affairs works to keep MSMS members up to date and informed. To that end, it is making available to MSMS members copies of the recent Reports of the Council on Scientific Affairs of the American Medical Association.

These reports, presented at 1981 and 1982 AMA Interim and Annual Meetings, cover a variety of subjects. Many have appeared in the *Journal of the American Medical Association.*

Interested physicians may request copies by contacting Frederick W. Bryant, MD, chairman, MSMS Committee on Scientific and Educational Affairs, 120 W. Saginaw St., East Lansing 48823.

Following is the list of the AMA Scientific Reports:

1981 AMA Annual Meeting

1. Risks of Nuclear Energy and Low-Level Ionizing Radiation
2. Drug Abuse Related to Prescribing Practices
3. Organ Donor Recruitment
4. The 1980 Report of the Joint National Committee on Detection, Evaluation and Treatment of High Blood Pressure
5. Evaluation of Iridology
6. Acupuncture
7. Electronic Fetal Monitoring

1981 AMA Interim Meeting

1. Health Effects of "Agent Orange" and Dioxin Contaminants
2. Genetic Counseling and Prevention of Birth Defects
3. Health Care Needs of the Homosexual Population
4. Prescription of Tranquilizers and Antidepressants for Women
5. Dimethyl Sulfoxide: Controversy and Current Status
6. Estrogen Replacement in the Menopause — 1981

1982 AMA Annual Meeting

1. Council on Scientific Affairs' Responses to the National Center for Health Care Technology and Office of Health Research, Statistics and Technology
2. Medical Evaluations of Healthy Persons
3. Sodium in Processed Foods
4. Continuous Ambulatory Peritoneal Dialysis (CAPD)
5. Infant Formula Marketing
6. Fetal Effects of Maternal Alcohol Use
7. Brain Injury in Boxing

1982 Interim Meeting

1. Addition of Thiamine to Alcoholic Beverages
2. Calcium Channel Blocking Agents
3. Physician Mortality and Suicide: Results and Implications of the AMA-APA Pilot Study
4. Percutaneous Transluminal Agioplasty (PTA)
5. Automobile-Related Injuries: Components, Trends, Prevention
6. AMA Involvement in Prevention and Treatment of Child Abuse and Neglect
7. Pneumococcal, Influenza and Hepatitis-B Vaccine
8. Dietary and Pharmacologic Therapy of the Lipid Risk Factors
9. Cochlear Implants
10. In-Utero Fetal Surgery
11. Revision of AMA Guides to Impairment

Michigan Medicine wins again!

Michigan Medicine is the recipient of a special award in the eighth annual Sandoz Medical Journalism Competition sponsored by the Sandoz, Inc., pharmaceutical company of East Hanover, NJ.

The award is the fourth top recognition earned by the official monthly MSMS publication in as many years of entering the competition. In 1978 the magazine won first prize. In 1981 and 1982 it earned honorable mention, the only recognition awarded other than first place.

The magazine has been ranked in a class of state medical society publications of 3,000 and over circulation. This year's first place winner is the *Journal of the Florida Medical Association*, and in 1982 it was *Texas Medicine.*

"*Michigan Medicine* is in a special class," wrote Craig D. Burrell, MD, vice president, Sandoz, Inc., in the letter announcing the award. "The judging . . . was more difficult this year than ever before, principally because of the larger number of excellent publications in the state medical journal category.

"We are therefore presenting five awards, which is unprecedented, . . . " Other state publications receiving special awards are those of the Iowa, Pennsylvania and Virginia state medical societies.

The award will be in the form of $250 and a certificate to be presented at the 1983 MSMS House of Delegates meeting.

The contest is based primarily on the design and editing strengths of the magazines which enter. *Michigan Medicine* ranked high in its dedication to its news and socio-economics format, its use of photographs, strong covers, special treatment of key issues and sound typography.

The award will be accepted at the House of Delegates meeting by Busharat Ahmad, MD, Marquette, chairman, MSMS Committee on Publications, which sets policy and direction for the magazine. Also on the committee are Harvey M. Andre, MD, Grand Rapids; James D. Fryfogle, MD, Detroit; Vickers C. Hansen, MD, Manistee; Charles L. Oppy, MD, Roscommon, and James H. Tisdel, MD, Port Huron.

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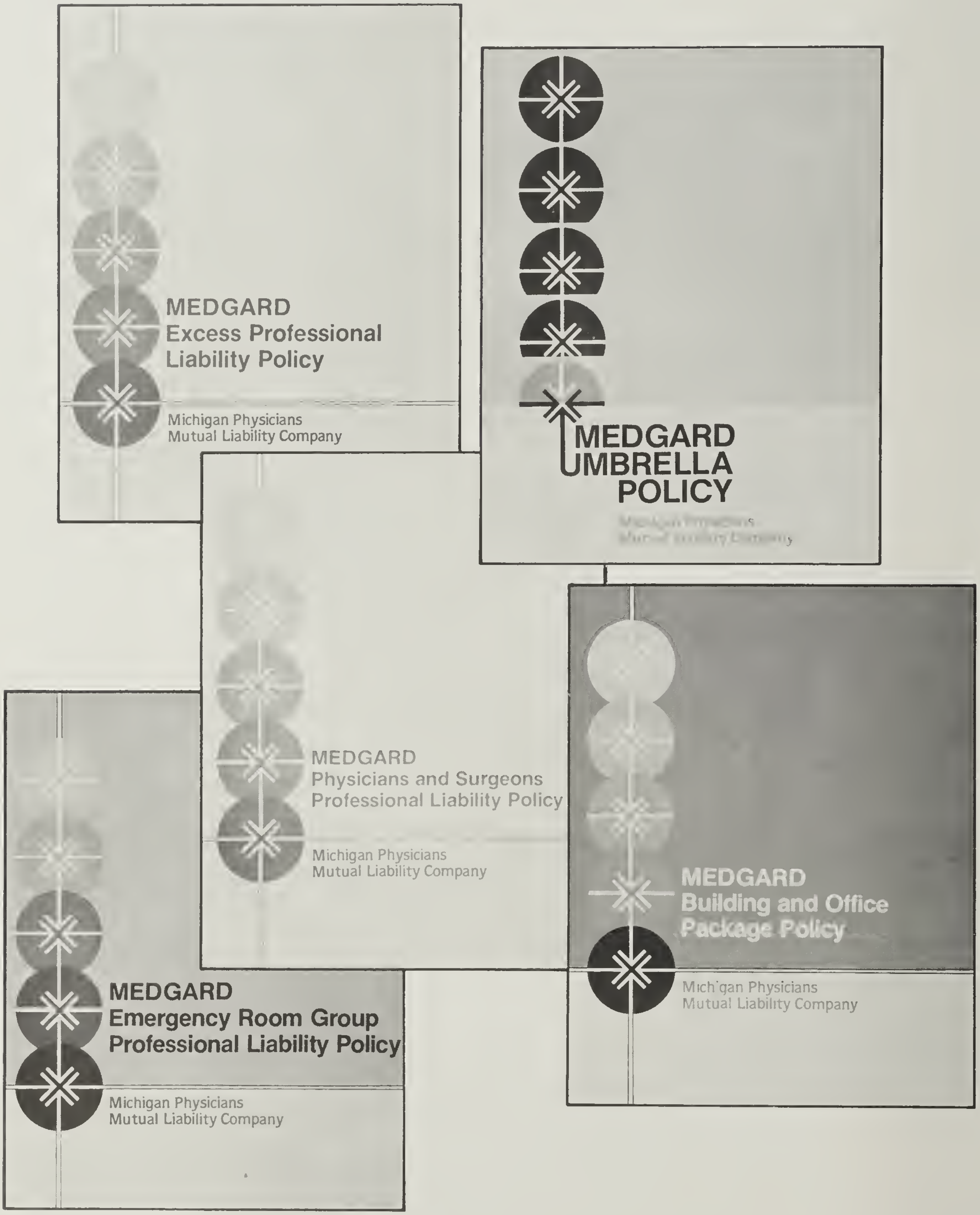

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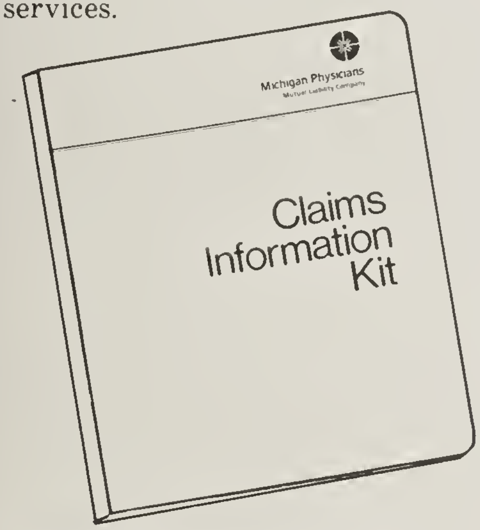

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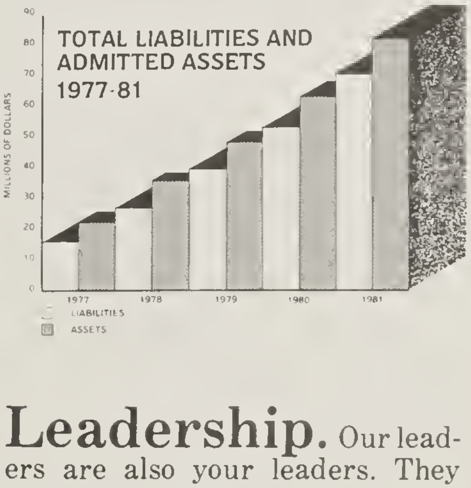

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Fees or use? what's responsible for rising health care costs?

By Miron Stano
Jerry Cromwell
Joseph Velky
Ali Saad
Detroit

What is responsible for Michigan's growing expenditures for health care? Is it inflation, doctors' fees, patients' use of medical care, or "all of the above?"

In the process of studying competition among physicians within the markets they serve, an economic analysis revealed some surprising answers. The parent study for this Health Care Financing Administration-supported research used the massive data from Blue Cross and Blue Shield's claims for 1977-1980.

The researchers created two new and highly accurate economic indices to describe health care fees and use. Inter-area cost differences and longitudinal trends are more clearly explained by the indices. One index pegs medical costs to the 1974 dollar. Data are reported using "real" (adjusted for inflation) dollars rather than "nominal" or actual dollars. The other index standardizes various medical procedure groupings into comparable units. In addition, there were adjustments to account for persons seeking physician care out of their region of residence.

The authors are, respectively, associate professor, School of Economics and Management, Oakland University; president, Health Economics Research, Inc.; manager, Health Care Research, Blue Cross-Blue Shield of Michigan; and research associate, Blue Cross-Blue Shield of Michigan. This research was supported by Grant No. 18-P-97619/5-01 from the Health Care Financing Administration.

Data and methods

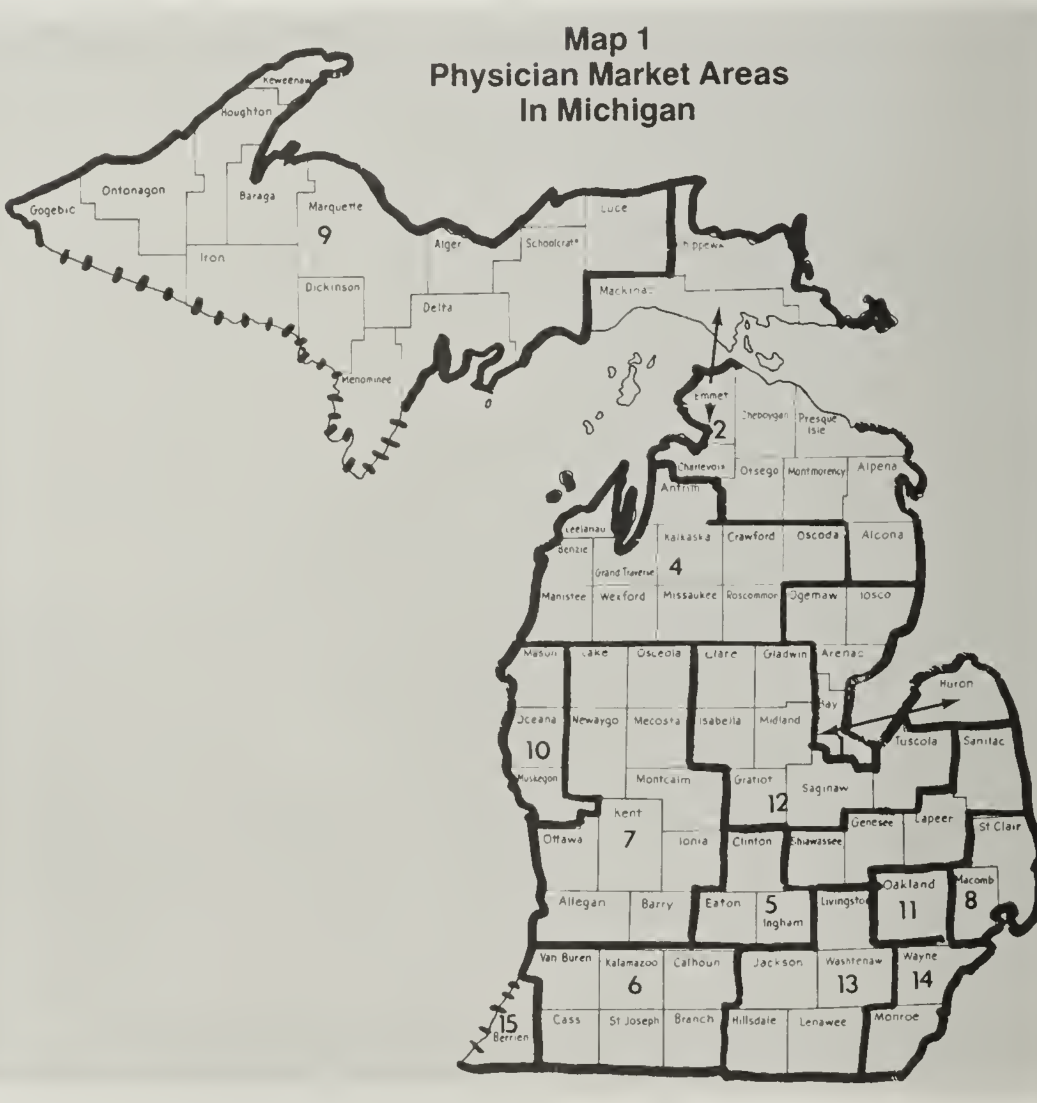
Working with a data file of 200 million records required reduction of the file to a more manageable size. Medical procedure codes with high frequency and/or high payout were selected. The criteria for minimum frequency of use for a procedure in a calendar quarter ranged from 200 for surgery and maternity to a frequency of 1,000 for medical care.

Procedures with lower frequencies of use were selected if the average charges were $1,000 or more — or $2,000 or more for frequencies between 10 and 49. From over 4,000 procedures, the most pertinent ones were reduced to a grand total (GT) of 424 codes.

Nonetheless, these procedures represented 56 percent of all services and 60 percent of all payments in Michigan. Ninety percent of surgical procedures and 74 percent of surgical payments were represented. In obstet-

Continued on page 230

Map 1
Physician Market Areas In Michigan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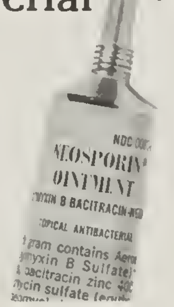

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rics and medical care, over 90 percent of payments were included. The grand total and the three specialty areas studied — surgery, obstetrics and medical care — were in economic terms comprised of "market baskets" of procedures.

A key to standardizing the heterogeneous procedures of the four market baskets was to index each procedure to a relative value. The common element in the scale was the *relative value unit* (RVU). The base unit chosen was procedure #9020 ("Brief office visit for an established patient"), which was assigned the RVU of one. The weights assigned to other procedures were determined by the ratios of their average statewide charges to the average statewide charge of procedure #9020. For example, if the average charge of one procedure is five times the average charge of #9020, it is assigned five RVUs. In this way, all the services received by patients can be aggregated into a measure of use which expresses the total RVUs per eligible beneficiary. The fee index which was developed measures the average charge per RVU.

The economics of location were applied to the resident origins of the patients and to where they obtained their medical services. Fifteen markets were identified within Michigan's counties and are shown in **Map 1.**

Because residents of one area often cross over to another area to obtain care, traditional measures of per capita use may significantly overstate or understate an area's true use rate. The calculations presented here have incorporated an adjustment for this "bordercrossing" between market areas.

Finally, a search failed to find any studies of physician fees which attempted to correct for cost-of-living (COL) differences across market areas in Michigan. A COL index was estimated for each of the 15 market areas (relative to the 1974 Detroit value) to convert nominal (actual dollars) fees into *real* (inflation adjusted) fees.

Physician fees

Nominal fees have grown rapidly between 1977 and 1980. Real, adjusted for cost-of-living, fees have not. Specifically, the statewide average increase in nominal charges ranged from 28 percent for obstetrics to 36 percent for surgery and averaged 33 percent for all 424 procedures. However, the growth rate in real fees averaged only 1.5 percent for these 424 procedures. Obviously physician fees are moving *with* the economy — not substantially ahead of it. Significantly, also, the growth rates in fees in the three largest (as measured by total Blue Shield use) markets (Detroit, Warren, and Southfield) were among the lowest in the state.

Table 1
Nominal and Real Charges Per RVU for Four Specialty Groups for 1980: Market Basket 'Grand Total'

Market Area	Nominal Charges Per RVU				Real Charges Per RVU			
(Major City)	1	2	3	4	1	2	3	4
1 (Bay City)	13.66	11.85	15.27	13.83	9.12	7.91	10.20	9.23
2 (Petoskey)	13.62	17.00	14.04	11.66	9.02	11.26	9.30	7.73
3 (Flint)*	14.80	15.40	16.07	14.24	9.69	10.08	10.52	9.32
4 (Traverse City)	12.74	8.33	14.22	11.30	8.57	5.60	9.57	7.60
5 (Lansing)	13.08	12.19	15.21	12.13	8.39	7.82	9.76	7.78
6 (Kalamazoo)	12.71	11.57	14.26	12.25	8.41	7.65	9.43	8.10
7 (Grand Rapids)	12.25	11.50	13.55	11.83	8.27	7.76	9.14	7.98
8 (Warren)*	15.13	1.592	16.66	14.28	9.46	9.95	10.42	8.93
9 (Marquette)	11.73	11.54	13.93	12.71	8.48	8.34	10.07	9.19
10 (Muskegon)	12.56	12.17	14.57	11.77	8.80	8.53	10.21	8.25
11 (Southfield)*	14.91	15.19	16.48	14.40	9.32	9.50	10.30	9.00
12 (Saginaw)	13.01	13.81	14.24	11.56	8.55	9.08	9.36	7.60
13 (Ann Arbor)	14.55	15.57	14.44	13.16	9.14	9.78	9.07	8.27
14 (Detroit)*	15.44	14.83	16.85	14.91	9.65	9.27	10.54	9.32
15 (St. Joseph)	11.52	11.93	13.61	10.63	7.64	7.91	9.02	7.05
State Mean	14.62	14.82	15.94	14.15	9.28	9.41	10.12	8.99
Market Area Mean	13.45	13.25	14.89	12.71	8.84	8.70	9.80	8.36

NOTE: 1 = Primary care; 2 = Other Medical Specialties; 3 = Surgical Specialties; 4 = Other Remaining Specialties. The * indicates high Blue Cross-Blue Shield penetration rate — high real income areas. The minimum and maximum values in each column are boxed in. Real charges are expressed in terms of 1974 Detroit area dollars. The State mean is the average across the State; while the market area mean is the simple average of the 15 market areas.

State averages, however, tend to hide large growth differences among the state's markets. For example, the growth of nominal charges for surgery ranged from 28.1 percent in St. Joseph to 45.2 percent in Muskegon; and for obstetrics, it ranged from 23.3 percent in Southfield to 41.6 percent in Flint.

The nominal charge levels also show a relatively high variation between markets. In 1980, for the grand total group, the maximum nominal charge was 26.7 percent higher than the minimum. Generally, the Detroit to Flint corridor, which also includes the Southfield and Warren markets, consistently has the highest nominal and real charges, while St. Joseph, Marquette, Grand Rapids, and Traverse City consistently show the lowest nominal charges.

Once the cost-of-living (COL) adjustments are introduced, however, the gap between high fee areas and other areas is considerably narrowed. The Detroit-Flint area continues to show the highest real charges, and St. Joseph the lowest charges. Marquette, which was the second lowest in nominal charges, jumps to the market area average. Whereas nominal charges for six market areas were $1 or more either above or below the area mean, all COL adjusted fees fall within $1 of their respective area means.

As for comparison among the three sub-groups of procedures, surgery charges have grown the fast-

Continued on page 232

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est, followed by medical care, with obstetrics growing the least. The percent of nominal change was 35.5 percent for surgery, but adjusted for inflation it was 3.1 percent. Real obstetric charges fell in this period.

Utilization

Our analysis of the use of the selected 424 medical procedures by area population includes two utilization measures. One shows the actual RVU quantity per 1,000 actual BCBSM population; while the other provides an adjusted (for bordercrossing between market areas) index of RVU use per 1,000 BCBSM population. The effects of this adjustment are in some cases quite striking. For example, in 1980 the unadjusted per capita use in Southfield and Ann Arbor was 39 percent and 20 percent, respectively, greater than our index of adjusted use. This was caused by large numbers of residents from other markets receiving care from physicians located in these two markets. Southfield and Ann Arbor can be viewed as major exporters of care. Detroit, on the other hand, imported substantial amounts of physician care by its residents, on balance, receiving services in other markets. It is clear that significant bordercrossing persists among markets, and a failure to deal with this fact can produce substantial distortion in calculating utilization rates.

Much of this distortion comes in markets with extremely high (e.g. Southfield) or low (e.g. Marquette) use rates. The unadjusted utilization per actual population tends to be much higher because the calculations ordinarily could not account for the non-residents immigrating for their health care. On the other extreme, Marquette would have its costs per BCBSM member understated because of the tendency of the Upper Peninsula patients to obtain service in lower Michigan.

Table 2
Physician Availability and Fees and Use

Market Area (Major City)	Physicians 100,000 Pop. (1980)	Nominal Charges/ RVU (1980)	Real Charges/ RVU (1980)	Effective RVU Use/1,000 Pop. (1980)
Oakland* (Southfield)	$\boxed{22.8}$	15.32	9.58	$\boxed{8067}$
Grand Traverse (Traverse City)	16.9	12.87	8.66	4526
Ingham (Lansing)	14.8	13.54	8.69	5495
Washtenaw (Ann Arbor)	14.6	14.16	8.90	6237
Wayne* *(Detroit)	13.2	$\boxed{15.59}$	9.75	7931
Muskegon (Muskegon)	12.3	13.11	9.19	4709
Genesee* (Flint)	11.9	15.06	$\boxed{9.86}$	7732
Kalamazoo (Kalamazoo)	11.6	13.16	8.70	4345
Emmett (Petoskey)	11.3	13.48	8.93	4357
Berrien (St. Joseph)	10.6	$\boxed{12.30}$	$\boxed{8.15}$	3766
Kent (Grand Rapids)	10.5	12.65	8.54	4591
Saginaw (Saginaw)	10.1	13.23	8.70	5175
Macomb* (Warren)	10.1	15.47	9.67	8000
Marquette (Marquette)	9.4	12.56	9.08	$\boxed{2799}$
Bay (Bay City)	$\boxed{8.5}$	14.25	9.52	5538
State	13.4	14.91	9.47	6892

Note: The *indicates high Blue Cross/Blue Shield — high real income areas and minimum and maximum values in each column are boxed in. The fee and use indexes are for all 424 procedures.

Even after the adjustment for bordercrossing, substantial differences remain in both the levels of use and rates of its increase among the market areas. For example, Southfield, Warren, Detroit and Flint have relatively effective use rates for the 424 procedures of approximately 8,000 RVU's per 1,000 population — almost three times Marquette's use rate. If small markets such as Marquette and St. Joseph are considered atypical, the use rates of the Detroit to Flint corridor are still about 80 percent higher than the Standard Metropolitan Statistical Areas of Kalamazoo, Grand Rapids and Muskegon.

Not only is use highest in the Detroit-Flint corridor, but their markets also had the highest increases in per capita use — approximately 20 percent over a short time span. These areas account for the large overall state increases.

Specialty groups

Another analysis consolidated 46 medical specialty codes in four specialty groupings: (1) primary care, (2) other medical specialties, (3) surgical specialties and (4) other remaining specialties for a more comprehensive analysis.

These four physician specialty groups have nominal and real charges for 424 medical procedures listed on **Table 1.** Surgical specialties have the highest nominal and real charges while the other remaining specialties had the lowest averages.

As in the market basket finding, large inter-area variations in fees are found which in this case are not reduced much by COL adjustments. The inter-area differences were largest for other medical specialties with the highest, Petoskey, twice as large as the lowest, Traverse City. The Petoskey area is a special case compared to the high charging Detroit to Flint corridor. Petoskey area totals are in part a function of small numbers of

Continued on page 234

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Fees, use, and physician availability

In recent years, there has been a concern that medical care markets were unlike other marketable services and not subject to the "laws" of supply and demand. It has been argued that physicians can attain target income levels despite competition from other physicians. The evidence used to justify this point of view is the alleged positive relationship of the per capita concentration of physicians with higher fees and similar positive correlations between use and the availability of medical resources.

To see whether these patterns hold for Michigan, the 15 markets are ranked from highest to lowest in terms of the number of physicians per 1,000 population **(Table 2)**.

From a casual inspection of the data, there is no obvious relationship between fees and physician availability. The $14.24 average in nominal fees for the first seven markets is 6.3 percent higher than the $13.39 average for the bottom eight. However, the difference is only 3.6 percent in real terms and in each case there are numerous exceptions to the hypothesis.

It is instead the four industrialized markets, with high medical prepayment concentrations, in the Detroit to Flint corridor, that stand out. Rigorous statistical tests on six years of data, in fact, confirmed that, other things held equal, increases in physician supply do not raise fees.

With regard to use, however, and although there are also notable exceptions, there is a stronger apparent relationship between physician availability and use. The first seven markets averaged 6,385 adjusted RVUs per 1,000 eligible population compared to 4,821 RVUs — a 32.4 percent difference — for the last eight.

As with fees, though, the positive impact of higher real income and wider medical prepayment penetration appears to be much more strongly associated with use. Multivariate statistical tests verified the importance of these and other socioeconomic variables.

Nevertheless, they indicated that increases in physician supply have a separate positive impact on demand, especially for surgical services.

Summary

Preliminary findings showed that:

(1) Physicians' fees do not stand out as the major cause of increased real costs. What physicians charged for their services exceeded the inflation rate by 1.5 percent for the period. With inflation currently slowing down, the trend in nominal physicians' fees can be expected to follow the moderate course.

(2) Patients increased their use of medical care by 17 to 25 percent for the four groups of procedures studied. Patient use, not doctors' fees are primarily responsible for the rapid growth in real spending on physician care. Should the low use by persons in rural and smaller city areas start catching up to the levels of use in metropolitan areas, the cost trend could accelerate.

(3) Areas of the state vary substantially in both fees and use. Cost-of-living adjustments, however, dramatically reduce the real differences in fees, and adjustments for patient border-crossing between the areas diminish the apparent differences in use rates. Wide differences in use rates, nevertheless, remain even after the bordercrossing adjustment.

(4) Many economic and demographic factors account for the variations in fees and use rates. Differences in physician availability, alone, have a positive impact on demand, and no significant effect on fees. Together they lead to higher total spending.

Instructions for authors

The following *Michigan Medicine* requirements are presented to help prospective authors submit articles proposed for publication.

Michigan Medicine does not publish scientific or technical articles, and has not done so since January, 1976. At that time, several readership surveys revealed that MSMS members preferred a news-feature-opinion format.

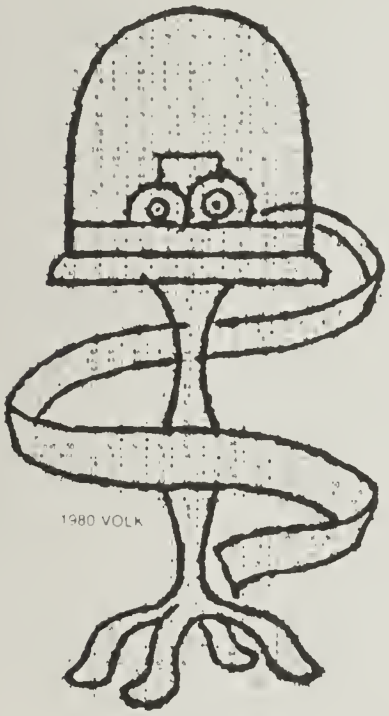
MSMS requests that proposed articles be typed, double-spaced, and no longer than 800 words in length (approximately 2½ pages). Please send two copies of the article. Also, please include a brief biographical paragraph outlining author's current professional position and recent accomplishments.

MSMS will review proposed articles on receipt and will let authors know within a few weeks whether MSMS can plan to publish the articles in *Michigan Medicine*.

For further details, please contact the editor at MSMS headquarters, 517/337-1351.

FINANCIAL PLANNING/ INVESTMENT PERSPECTIVES

Mutual funds are back!



By Daniel Ludwin
Cleveland

They offer diversification, flexibility, performance — who could ask for more?

Traditional mutual funds are making a comeback. When we say "traditional," we're referring to the stock and bond funds rather than the money-market mutual funds which have gained wide popularity. This renewed interest in funds, more properly called open-end investment companies, is due to their outstanding performance in the recent past. In fact, the average stock fund's net asset value rose over 100 percent in the last five years. This performance, coupled with the recent bull market, has spurred record sales for the mutual fund industry.

Mr. Ludwin is senior vice president of Prescott, Ball and Turben, investment bankers and brokers, East Lansing. He is consultant to the MSMS Board of Managers on the investment of the MSMS capital and creative reserve funds assets. He has 15 years' experience in the financial field.

But let's go back for a moment to the basic concept of a mutual fund and some of the features that make it an attractive investment vehicle. When you purchase shares in an open end investment company you're mak-

Continued on page 236

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ing a "complete investment." In other words, you have purchased shares of a widely diversified, professionally managed investment account. At any time, you may make additional purchases or withdrawals.

The value of your account will be worth either more or less than you have put in depending on the value of the underlying securities. For this reason, a mutual fund should be considered a long-term investment. Let's pose some questions you would probably ask if you and I were discussing a potential investment in mutual funds over a cup of coffee.

Q: Are mutual funds safe?

A: If you mean guaranteed, obviously not, since the value of the fund's shares is subject to market fluctuation. However, there are safety features. A bank or trust company usually acts as custodian for the fund's cash and securities. Auditing by a public accounting firm is required once a year. And mutual funds are subject to a variety of state and federal regulations. Also, you must be given a prospectus before you invest which, along with other sales and promotional materials, is subject to Securities and Exchange Commission scrutiny.

Q: What type of accounts are available?

A: Actually, there are four different types: (1) a regular or lump-sum account, (2) a regular account with automatic dividend reinvestment, (3) an accumulation account and (4) a withdrawal account.

Q: Would you explain the last three?

A: Sure. The automatic dividend reinvestment account will purchase additional shares in the fund instead of sending you a check. This provides a convenient method of building up your investment. The accumulation account is used where you don't have a lump sum to invest but wish to make periodic purchases. This method works well for "dollar cost averaging." The withdrawal account is used for the systematic liquidation of an investment. Say you have $50,000 and want to provide income for the next 10 years. You would automatically get one-tenth of the investment each year based on the net value each month or whatever payment period you choose. If the fund's share value increases, you have helped to hedge yourself against inflation.

Q: What does it cost to buy a fund?

A: That depends on the type you buy and how much you invest.

Q: Please explain.

A: A "front-end," or "load" fund will charge a one-time commission between one and one-half percent to eight and one-half percent, depending on the amount of money invested. "No-load" funds are purchased directly from the specific management company, thereby bypassing the salesman and the commission.

Q: Why would I ever buy a "load" fund?

A: Remember, long-term performance is the primary reason you select any fund group (all results are net of fees). So the question actually is:

Do I have the resources and the time to: (1) Find the superior fund groups? (2) Monitor their performances on a timely basis? (3) Monitor the individual managers who are creating the attractive track records to make sure they stay with the fund! (4) Select the fund (investment philosophy) which makes the most sense during any given economic environment?

Q: What do you mean by "fund groups"?

A: If you select a "fund group" (i.e., multiple funds with different objectives) you have the added flexibility of adjusting your investment objectives by changing funds within that group — at no cost.

Q: Why is that important?

A: Nothing is forever! While money market funds were the place to be a year or two ago, equity funds appear to be the best place for now. Next year — who knows? Wouldn't it be nice to have the flexibility to adjust as times change?

Q: Where are the funds appropriate?

A: Almost everywhere! But they seem especially well suited for IRAs and pension/profit sharing accounts. They offer the diversification, flexibility and performance to make them attractive.

Q: How can I decide which one is best for me?

A: By doing a little research. Determine your financial objectives, and the amount of risk you are willing to take. Then ask your broker for recommendations. Don't be afraid to ask a lot of questions.

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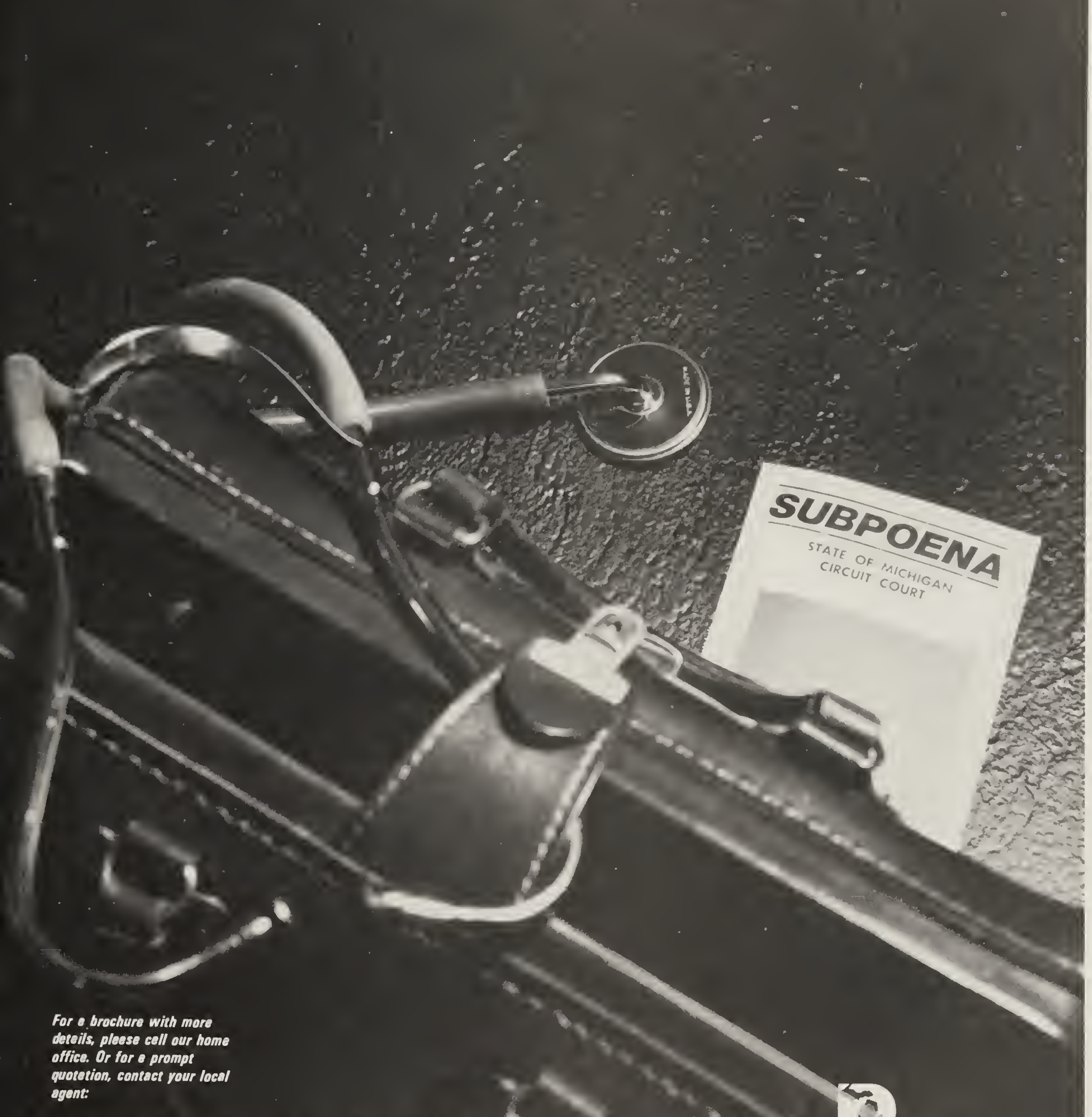

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Is there a DRG system in your future?

By Deborah Zannoth
East Lansing

The DRG system of hospital reimbursement has tremendous implications for the role of the hospital administration and the relationships between the hospital and its physicians. New Jersey has had a prospective reimbursement system based on DRGs since 1980. Although the verdict in New Jersey re DRG reimbursement as cost effective is still out, the Department of Health and Human Services has announced plans to implement a similar system for Medicare in October 1983.

Containing the spiral of health care costs has become a prominent issue within the Reagan Administration and Congress.

Health care spending has hit 9.8 percent of the gross national product. Medicare spending accounted for $73 billion for government spending in 1981, of which $42 billion was spent on hospital care alone.

Medicare control

In an effort to control Medicare hospital costs, the administration has officially proposed a new hospital reimbursement system for Medicare based on diagnostic related groups (DRG). This system is designed to reimburse the hospital on how much each DRG case costs on average as opposed to what each individual case costs.

Under current hospital reimbursement a hospital is paid all costs, regardless of diagnosis, and payment usually is made retroactively. The DRG prospective reimbursement system will tell hospitals in advance how much Medicare will pay for a diagnosis. Thus hospitals will be encouraged to budget their spending in order to meet expected reimbursement limits.

Diagnostic related groups is a concept developed by a group at Yale University. The researchers were examining average lengths of stay (ALOS) and their objective was to develop a classification system that had a narrow enough range of length of stay so that a meaningful study could be enacted.

Their research found 83 major diagnostic categories which since have been subdivided into 467 DRGs.

DRGs represent a homogeneous grouping of patients who require roughly the same treatment of care. If these patients require the same treatment of care it is assumed they will use similar amounts of hospital resources.

The DRGs were designed to be "medically meaningful" in that physicians are able to distinguish between each group by their clinical traits and to identify particular management patterns for them. It is assumed that the quantity and nature of the resources consumed by patients within a DRG is similar, yet different across DRGs. This is important because then the DRG classification scheme can be used as a method for calculating the amount of services a hospital provides, thus enabling a system for the determination of payment to a hospital based on the DRG.

Under the New Jersey system a hospital is reimbursed a specific DRG rate for each case, the rate to have been prospectively determined. (It is important to note that New Jersey initiated a hospital rate setting commission concurrent with implementing the DRG system.)

The hospital receives the same rate for all patients in a DRG regardless of length of stay or amount of services consumed, although the New Jersey plan has made some allowance for extremely short or extremely long stays.

Actual cost

The reimbursement rate is intended to reflect the actual cost of caring for that type of patient. Hospitals in New Jersey either retain the difference or make up for the loss between the DRG rates and the actual costs of care. Thus a clear incentive exists for administrators to minimize costs.

Last year hospital costs in New Jersey rose three percent less than did those of the rest of the country; but New Jersey costs still rose 14 percent over the previous year.

The AMA position is that DRGs need more testing and that such an untried system should not be imposed nationwide. The AMA supports experimenting with prospective payment systems and feels that several demonstration projects should be initiated which could lead to an effective prospective methodology.

AMA leaders also are afraid that a DRG system could create one level of care for private-pay patients and another level for Medicare patients.

The American Hospital Association supports a DRG plan but proposes modifications to make such a system more acceptable. They propose that DRG rates be "hospital-specific," rates based on each hospital's cost of treating patients by DRG in a prior base year, and that an assignment/non-assignment provision (similar to the option physicians have under Medicare Part B) be adopted.

From all discussions, however, it is apparent that a DRG prospective reimbursement system will be implemented in some fashion in the future. It also is likely that hospital administrators under a DRG system will be concerned with physicians' behavior and patterns of practice. The hospital will be able to track DRGs by department, and by physician as well. Thus administrators will be required to work closely with the physician staff in order to control costs and to effectively manage hospital resources while maintaining quality of care.

Ms. Zannoth is assistant to the MSMS Bureau of Economics.

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There is much you and I can do about medical care cost containment

By Peter A. Duhamel, MD
Rochester

COST
EFFECTIVE
MEDICINE

The following is reprinted with permission from the Oakland County Medical Society *Bulletin*. It is presented at the suggestion of the MSMS Task Force on Medical Care Costs as part of its continuing series to help MSMS members learn better to contain health care costs.

Doctor Duhamel is president of the Oakland County Medical Society.

At the recent Congress of the American College of Surgeons in Chicago, there was the usual presentation of many new techniques and instruments (some of them in the "gimmick" category, e.g. a zipper to close the skin.)

There was also the opportunity to meet with many surgeons from other areas, both in private and hospital or university-based practices.

It is remarkable how frequently the topic of cost containment came up, both in the evaluation of the many new techniques and instruments, but also in discussing the social, political, and economic forces that we all are facing in our practices every day.

. . . all the new medical technology carries a heavy price tag. And we should be concerned that there is a possibility that certain physicians, motivated by profit, would be somewhat lax in their indications for the use of these expensive new techniques.

I don't know that the insurance carriers are really the ideal parties to determine what is a fair and reasonable fee. And any "negotiation of benefits" between representatives of the medical or specialty society and the carriers might be looked upon with disapproval by the FTC!

We physicians feel that we are unfairly receiving much of the blame for the rapidly escalating health care costs. The government agencies, the health care planners, the third party carriers, the employers, the labor unions, and the individual patients, who are pointing their accusing fingers at physicians — all of these parties also must share in the blame for these cost increases.

However, there is much that we physicians can and should do in the interest of cost containment. We are the ones who admit the patients to the hospitals, order the various tests, consultations, and procedures, perform whatever procedures are done, prescribe the antibiotics and other costly medications, and determine when the patients are to be discharged. I'm sure we have always done all these duties with the well-being of the patients as our primary concern, and not ever with the intention of simply running up the cost, ordering only those tests, etc., which we considered truly necessary.

But, there are many things we can do (or NOT do) that may help to decrease some of these costs.

Many surgical procedures customarily done in the in-hospital setting are now being regularly scheduled as out-patient procedures, and the list of out-patient procedures is growing monthly.

It usually is not necessary to admit patients two or three days early to prepare them for scheduled surgery, as pre-admission testing, consultation, even bowel-preparation can be done ahead of time. The number of doses of antibiotics after surgery can in many cases be diminished to two or three.

These topics and many others were brought up frequently at the recent ACS Congress, and I'm sure that many of you in other specialties can search for ways to decrease the numbers of "routine" daily tests ordered, the need for all the CAT scans and other sophisticated procedures, the excessive use of antibiotics and other medications, length of stay in CCU or ICU. The list is endless.

My message is that there is much you and I and every practicing physician can do about cost containment. We may not see much benefit in the beginning, but it will make a sizeable difference in the health dollars spent in this area in the long run.

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INDICATIONS: Adjunct in short-term treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease Clinical trials demonstrated in these situations relief of pain is somewhat greater than with aspirin alone Effectiveness in long-term use, i.e over 4 months, has not been assessed by systematic clinical studies Physicians should periodically reassess usefulness of drug for individual patients

CONTRAINDICATIONS: ASPIRIN Allergic or idiosyncratic reactions to aspirin or related compounds MEPROBAMATE Acute intermittent porphyria, allergic or idiosyncratic reactions to meprobamate or related compounds, e g carisoprodol, mebutamate, or carbromal

WARNINGS: ASPIRIN Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes

MEPROBAMATE DRUG DEPENDENCE Physical and psychological dependence, and abuse have occurred Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo, Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e g anxiety, anorexia, or insomnia, or withdrawal reactions, e g , vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis, and, rarely, convulsive seizures Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation, symptoms usually cease within next 12-to-48-hour period When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn

POTENTIALLY HAZARDOUS TASKS Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e g , driving or operating machinery

ADDITIVE EFFECTS Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they be-become pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels.

USAGE IN CHILDREN Keep preparations with aspirin out of reach of children Equagesic®-M is not recommended for patients 12 years of age and under

PRECAUTIONS: ASPIRIN Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics

MEPROBAMATE Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation Meprobamate is metabolized in the liver and excreted by the kidney, to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function Meprobamate occasionally may precipitate seizures in epileptic patients It should be prescribed cautiously and in small quantities to patients with suicidal tendencies

ADVERSE REACTIONS: ASPIRIN May cause epigastric discomfort, nausea, and vomiting Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur Patients receiving large doses of salicylates may develop tinnitus

MEPROBAMATE CNS Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity

GI Nausea, vomiting, diarrhea

CARDIOVASCULAR Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis

ALLERGIC OR IDIOSYNCRATIC Milder reactions are characterized by itchy urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate/mebutamate and meprobamate/carbromal Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis Stevens-Johnson syndrome and bullous dermatitis have occurred

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC") Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura

OTHER Exacerbation of porphyric symptoms

DOSAGE AND ADMINISTRATION: Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present Not recommended for patients 12 years of age and under

OVERDOSAGE: Treatment is essentially symptomatic and supportive Any drug remaining in the stomach should be removed Induction of vomiting or gastric lavage may be indicated Activated charcoal may reduce absorption of both aspirin and meprobamate Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported Acute simple overdose (meprobamate alone) Death has been reported with ingestion of as little as 12 gram meprobamate and survival with as much as 40 gram.

BLOOD LEVELS:

0 5-2.0 mg percent represents usual blood-level range after therapeutic doses The level may occasionally be as high as 3 0 mg percent

3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment Some fatalities occur.

At levels greater than 20 mg percent, more fatalities than survivals can be expected

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol) Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels Any drug remaining in stomach should be removed and symptomatic treatment given Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration.

Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption

HOW SUPPLIED: Bottles of 50 scored tablets

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Here is the final FTC order, interpreted and printed in entirety

The FTC recently issued a final order in its legal action against MSMS which directs MSMS to refrain from engaging in certain activities. As required by the FTC, the full text of the final order appears in this edition of *Michigan Medicine.* Preceding the text of that order is a commentary which is intended to introduce and explain pertinent portions of the final order. This commentary is not intended to be and should not be treated as a substitute for the text of the final order. You should read the commentary and the order itself.

Introduction

After years of protracted litigation, the Federal Trade Commission (FTC), in February of 1983, issued a final order in its legal action against the Michigan State Medical Society (MSMS). The FTC's Final Order held that MSMS was responsible for unreasonably restraining competition in the health care industry by conspiring with its members to influence physicians' reimbursement policies of health care insurance carriers (e.g. Blue Cross/Blue Shield of Michigan [BCBSM] and Michigan Medicaid).

The Final Order was the result of an appeal taken by MSMS from an initial decision rendered against MSMS in June of 1981 by Administrative Law Judge Thomas F. Howder (ALJ order). The final order upheld the basic legal and factual findings of the ALJ order.

Specifically, the FTC's final order found that MSMS had unlawfully engaged in the following conspiratorial activities:

- MSMS and its members attempted to negotiate collective price fixing agreements with health insurance carriers (e.g. BCBSM and Michigan Medicaid).
- MSMS and its members agreed to use coercive measures (e.g. proxy solicitation and group boycotts) in an effort to influence physicians' reimbursement rates set by the health insurance carriers.
- MSMS and its members used coercive threats in order to force health insurers to adopt certain physicians' reimbursement policies.

As a result of these findings, the final order directs MSMS (including MSMS component societies and specialty sections) to refrain from engaging in future conspiratorial or coercive activity with respect to health insurance reimbursement rates for services rendered by physicians.

Although the final order upholds the findings of the ALJ order by prohibiting MSMS from engaging in four particular activities related to physicians' reimbursement policies, the final order modifies and clarifies the ALJ order by *narrowly defining* the boundaries of these specific prohibitions (explained in detail below). Consequently, the FTC's final order (unlike the ALJ order) assures a very limited interference with the First Amendment rights of MSMS, its component societies, specialty sections and members.

Specific prohibitions issued by the FTC

The FTC's final order proscribes MSMS (including MSMS component societies and specialty sections) from engaging in the following activities:

- MSMS is prohibited from entering or attempting to enter into *any agreement or understanding with any MSMS member(s)* which could result in the fixing of a health insurer's reimbursement terms for physicians' services.
- MSMS is prohibited from *recommending or advocating to any MSMS member(s)* that they engage in the above mentioned price-fixing activities.
- MSMS is prohibited from entering into *any agreement or understanding (tacit or otherwise) with any health insurer* (e.g. BCBSM or Michigan Medicaid) concerning physicians' reimbursement policies.
- MSMS is prohibited from making *express or implied threats or engaging in any coercive activities* (e.g. group boycotts or proxy solicitation) *in an effort to compel or induce* a health insurance carrier to adopt an MSMS position regarding physicians' reimbursement terms.

These prohibitions are directives from the FTC and should not be considered mere cautionary guidelines. As the FTC explained in its 54-page opinion which supplements the final order: "Our clear purpose in crafting a remedy is to prevent agreements and boycotts or similar coercive threats of collective action to fix or affect prices. We believe that it is necessary and appropriate to prohibit MSMS and its members — direct competitors in the eyes of the law — from agreeing or joining together to affect specifically reimbursement amounts, terms or methods of calculation."

FTC's narrow construction of prohibitions

Although the four directives outlined above could be interpreted to cover a broad range of activities, other provisions of the final order, and the FTC opinion which supplements the final order, assure that the four prohibitions issued against MSMS are to be *narrowly construed.* "The ALJ's order, as modified [by the final order], does not impose an outright prohibition on MSMS expressing its views or the views of its members to third-party payers (e.g. BCBSM). Stated as plainly as possible, [the final order] would not preclude communications that fall short of agreements or attempts to reach agreements on reimbursements."

Specifically, the FTC allows MSMS the right to engage in the following activities:

1) The prohibited activities addressed in the final order would affect only the actions of MSMS *as a corporation and those individuals acting on behalf of MSMS as "official representatives or agents" of the medical soci-*

ety. Personal opinions (designated as such) on issues concerning physicians' reimbursements would not be proscribed under the final order. The FTC opinion explicitly emphasizes that even officers of MSMS can speak out on reimbursement subjects if they are careful in presenting their views as personal views and not the views of MSMS or its members.

2) The final order does not prohibit MSMS from acting as an agent or representative for its members *in all matters.* "We emphasize that we are not proposing to prohibit all collective activity simply because they may have some possible effect on fees." Only the subjects specifically proscribed by the final order are off limits; namely, areas where MSMS is actually attempting to *negotiate* reimbursement rates for services rendered by physicians.

3) The final order allows MSMS to provide its views and information to insurers (e.g. BCBSM or Michigan Medicaid) on its own behalf or on behalf of its members without fear of violating the final order *"so long as MSMS makes no attempts whatsoever to extract agreements, through coercion or otherwise, from those third-party insurers on reimbursement issues."* MSMS, its representatives and members, therefore, are free under the protection of the First Amendment to engage in any *"non-binding, non-coercive discussions with health insurers" on any subject matter whatsoever, including correspondence concerning physicians' reimbursement policies.*

"For example, the mere fact that MSMS conveys its concerns to BCBSM or Michigan Medicaid about a particular reimbursement policy, and the third party insurer thereafter changes its policy, is unlikely, without more, to be construed as an agreement prohibited by the order. If, however, the overall course of dealing indicates that [MSMS] is acting in a fashion that purportedly commits its members collectively to accept or reject a third-party proposal, the chances are much greater that the order will apply."

It is apparent from the FTC's discussion of the final order in its supplemental opinion that the four prohibitions are narrowly directed toward proscribing MSMS from encouraging its members to engage in concerted activities or agreements which would affect the price of physicians' services or from undertaking such activities itself.

"In allowing [MSMS] to engage in non-binding, non-coercive discussions with health insurers, we have attempted to strike a balance between the need for insurers to have efficient access to views of large groups of providers and the need to prevent competitors from banding together in ways that involve unreasonable exercise of collective market power."

MSMS activities not affected by the FTC's final order

The final order additionally identifies three important activities which MSMS may continue to undertake:

- MSMS may participate in peer review activities concerning fees charged by individual physicians in specific cases.
- MSMS may exercise its First Amendment rights by expressing itself before any state or federal government agency or body concerning legislation or rules of any administrative or judicial proceeding (e.g., MSMS would not be prohibited from participating in any proceeding of a state agency regarding Medicaid issues). So long as MSMS does not seek to extract any agreement or otherwise engage in a prohibited course of behavior, MSMS would not be barred from advocating to the legislature or any other state agencies its views on all aspects of physicians' reimbursement policy.
- MSMS may provide information or its viewpoint, on its own behalf or on behalf of its members, to any helath insurance carrier concerning any issue, including reimbursement topics. While MSMS is prohibited from entering into any type of coercive activity or agreement with these insurance companies concerning reimbursement issues, the FTC is of the opinion that MSMS may have a *"useful role to play"* in offering suggestions and advice to health insurers on a variety of issues, including reimbursement topics. Therefore, MSMS' contact with these health insurers is not limited to responsive communications, but extends as well to similar communications initiated by MSMS or one of its component societies, specialty sections or members.

It is evident from the above outline of the final order, that MSMS has considerable latitude in voicing an opinion for and on behalf of its membership without violating the final order so long as that voice does not begin to sound like a hardened agreement or threat to fix prices or reimbursement terms for physicians' services.

In its concluding remarks, the FTC cautiously stated that:

"There is, of course, some inherent danger in allowing any collective dialogue with third-party payers on questions directly related to reimbursement amounts or policies. Nevertheless, we believe that this risk is reasonable so long as the order clearly proscribes agreements with third-party payers, whether extracted by negotiation or coercion, and any conduct in furtherance of such a result. As we pointed out previously, our order permits the efficient exchange of information and ideas between providers and insurers while guarding against the concerted imposition of price-related agreements by competing health care providers."

Final order

This matter having been heard by the Commission upon the appeal of respondent from the initial decision, and upon briefs and oral argument in support thereof and in opposition thereto, and the commission having determined for the reasons stated in the accompanying opinion to deny the appeal of respondent:

It is ordered that the initial decision of the administrative law judge be adopted as the findings of fact and conclusions of law of the commission, except to the extent inconsistent with the accompanying opinion. Other findings of fact and conclusions of law of the commission are contained in the accompanying opinion.

It is further ordered that the following order to cease and desist be, and it hereby is, entered.

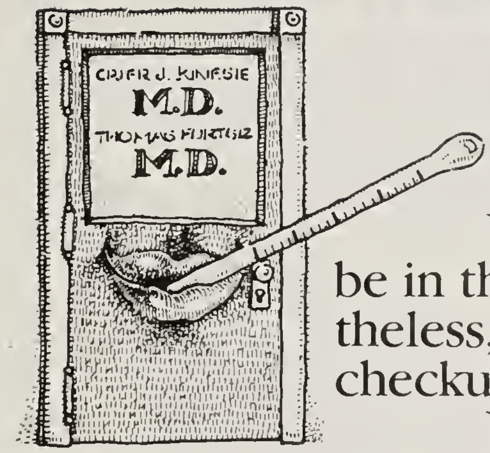
I.

It is ordered that for purposes of this order the following definitions shall apply:

A. "MSMS" means Michigan

Continued on page 246

THOROUGH DAILY CHECK-UP.



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FTC/*Continued*

State Medical Society, its House of Delegates, Council, committees, officers, representatives, agents, employees, successors and assigns.

B. "Third-party payer" means any person, corporation, government agency or other entity which agrees to pay for or reimburse all or part of any expense for physicians' services incurred by another person or group of persons. "Third-party payer" includes, but is not limited to, Blue Cross and Blue Shield of Michigan, and Medicaid.

C. "Medicaid" means the program of health care for indigent persons created by Title XIX of the Social Security Act, entitled "Grants to States for Medical Assistance Programs," 42 USC S 1396 *et seq.* (1976 & Supp. III 1979), including regulations, policies and procedures of Michigan that implement the program in Michigan.

D. "Reimbursement" means money paid by a third-party payer for physicians' services.

E. "Physician" means a doctor of medicine or of osteopathy.

F. "Participation agreement" means any agreement between a third-party payer and a physician in which the third-party payer agrees to pay the physician for the provision of physicians' services and in which the physician agrees to accept payment from the third-party payer for the provision of physicians' services.

II.

It is further ordered that MSMS shall cease and desist from:

A. Entering into or attempting to enter into any agreement or understanding, either express or implied, with any MSMS members to affect or attempt to affect the amount, manner of calculating, or terms of reimbursement, including but not limited to, any agreement or understanding that:

1. any MSMS members will cancel or refuse to enter into participation agreements;

2. any MSMS members will refuse to complete claim forms used by any third-party payer;

3. MSMS can act on behalf of any members through proxy, power of attorney, or otherwise, to cancel or refuse to enter into any participation agreement; or

4. any MSMS members will sign or enter into participation agreements only on terms acceptable to MSMS or to any other MSMS member.

B. Advocating, suggesting, urging, advising, inducing or recommending that any MSMS members engage in any action to affect or attempt to affect the amount, manner of calculating, or terms of reimbursement, including, but not limited to, advocating, suggesting, urging, advising, inducing or recommending that any MSMS members:

1. cancel or refuse to enter into any participation agreement with any third-party payer;

2. refuse to complete claim forms used by any third-party payer.

3. agree to permit MSMS to act on behalf of any MSMS members through proxy, power of attorney, or otherwise, to cancel or refuse to enter into any participation agreement; or

4. sign or enter participation agreements only on terms acceptable to MSMS or to any other MSMS member.

C. Entering into or attempting to enter into any agreement or understanding, either on its own behalf or as representative of any of its members, with any third-party payer concerning the amount, manner of calculating, or terms of reimbursement, or concerning the decision of any of its members jointly to accept or reject the terms or conditions of any participation agreement.

D. Making any express or implied threat of acts by any MSMS members, or engaging in any other acts, with the purpose or effect of coercing, compelling or inducing any third-party payer to accept a position taken by MSMS or any MSMS members concerning the amount, manner of calculating, or terms of reimbursement, or the terms or conditions of any participation agreement.

III.

It is further ordered that this order shall not be construed to prevent MSMS from:

A. Participating in professional peer review of fees charged by individual physicians in individual cases.

B. Exercising rights permitted under the First Amendment to the United States Constitution to petition any federal or state government executive agency or legislative body concerning legislation, rules or procedures, or to participate in any federal or state administrative or judicial proceeding.

C. Providing information or views, on its own behalf of its members, to third-party payers concerning any issue, including reimbursement.

IV.

It is further ordered that MSMS:

A. Mail a copy of this decision and order to each of its component societies, each of its specialty sections, and a copy of the order to each of its members within 30 days following service of this order.

B. Publish this order in an issue of *Michigan Medicine* published no later than 60 days after the date the order is served, and in the first *Medigram* published after the order is served. The order shall be published in the same type size normally used for articles which are published in *Michigan Medicine* and in the *Medigram.*

C. For a period of three years, provide each new MSMS member with a copy of this order at the time the member is accepted into membership.

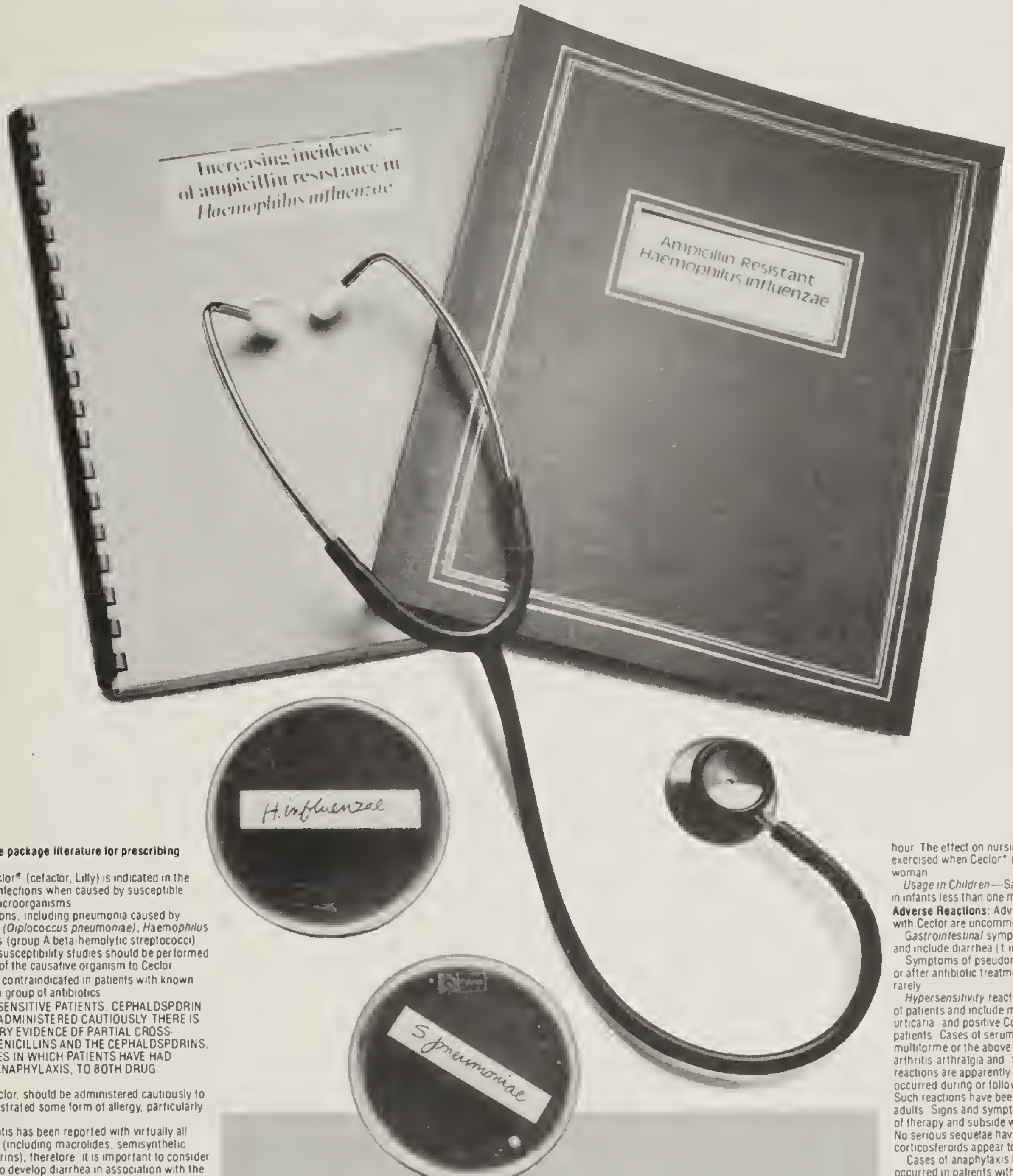
D. Require, as a condition of affiliation with MSMS, that any component society or specialty section agree by action taken by its governing body to be bound by the provisions of parts I-III of this order.

V.

It is further ordered that MSMS shall file a written report with the commission within 90 days of the date of service of this order, and annually on the anniversary date of the original report for each of the five years thereafter, and at such other times as the commission may by written notice to MSMS require, setting forth in detail the manner and form in which it has complied with this order.

It is further ordered that MSMS shall notify the commission at least 30 days prior to any proposed change to itself, such as dissolution, assignment, or sale resulting in the emergence of a successor corporation or association, or any other change which may affect compliance with this order.

An added complication... in the treatment of bacterial bronchitis*


Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin Resistant Haemophilus influenzae
H. influenzae
S. pneumoniae

Brief Summary. Consult the package literature for prescribing information.

Indications and Usage. Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae)*, *Haemophilus influenzae*, and S *pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS, AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy, particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy, appropriate bacteriologic studies, and fluid, electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe, oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile* Other causes of colitis should be ruled out

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary, the patient should be treated with appropriate agents, e g pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs' testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0 18, 0 20, 0 21, and 0 16 mcg ml at two, three, four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor® (cefaclor Lilly) is administered to a nursing woman

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria and positive Coombs' tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis arthralgia and frequently fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported, half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count, predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

---

*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either S *pneumoniae* or H *influenzae* [8]

Note Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

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8 Principles and Practice of Infectious Diseases (edited by G L Mandell, R G Douglas, Jr , and J E Bennett), p 487 New York John Wiley & Sons, 1979

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Occurrence screening — What do you think?

By Thomas R. Brown, PhD
Detroit

Here's support for a new proposal to assure high quality health care. Do you support this proposal? How do you feel about the author's arguments? Below is space for you to comment on this issue. Jot down your reaction and send to the Editor, *Michigan Medicine,* 120 W. Saginaw St., East Lansing, 48823. We'll publish the best responses in the next edition of this new column.

Occurrence screening, a state of the art quality assurance (QA) methodology, can reduce the time demands on a physician, yet increase the kind of results the Joint Commission on Accreditation of Hospitals has asked for in its current recommendations.

At the same time it is refreshingly simple and logical.

Until now, our activities such as utilization reviews and medical audits have been time-consuming and at best, marginally successful. We have come to view them as necessary inconveniences.

The JCAH's current request for documented evidence of improved patient care through QA activities sounds like more frustration at first. But it doesn't have to translate to more committee time with more trivial returns. Accompanying the message is a very flexible new QA standard that opens the door for alternative methodology.

Occurrence screening rejects the old approach of 100 percent com-

Doctor Brown is a member of the Hutzel Hospital Medical Staff Quality Assurance Committee. In addition he is a research associate in the Section of Endocrinology, Department of Medicine, Hutzel Hospital, and an assistant professor of physiology, Department of Physiology, Wayne State University School of Medicine.

I agree (disagree) and here's why:

COORDINATOR OF BURN SERVICE

Hurley Medical Center, a 573-bed teaching medical center with University affiliation in Flint, Michigan, is recruiting a quarter-time Physician as Coordinator of its Burn Program.

The successful applicant will have responsibility for the administrative aspects of the program and coordination of the overall burn care delivery including Emergency Room, Operating Room, Recovery Room, and the Burn Unit. The individual will participate in the education of residents, nurses and other health care professionals, and the community at large. In addition, the individual will represent the Burn Program for the Department of Surgery and will be responsible for maintaining the program at a high level of excellence.

Applicants must be board-certified in Surgery and have at least two year's experience in the care of Burn patients. Position offers a $15,000 quarter-time salary base with private practice opportunities. If interested, please send letter of application and curriculum vitae to:

Alexander Nehme, M.D.
Director of Surgical Education
Hurley Medical Center
One Hurley Plaza
Flint, MI 48502

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pliance with standards of high quality care. It presumes that these standards are inherently nebulous and that they tend to reduce clinical care to cookbook medicine.

Occurrence screening attacks the issue from the opposite direction. It seeks to reduce the occurrence of "disquality" care so that quality assurance becomes disquality prevention.

Unlike standards of high quality care, the exceptions to quality can be defined objectively by approximately 20 criteria, each of which may indicate an adverse patient occurrence.

Besides being objective the criteria also are comprehensive and not diagnosis-specific. Often they are referred to as generic. Trained medical record personnel can screen for them and, as they occur, direct them to the attention of the appropriate QA person or committee.

Included in the criteria are "previous admission for the same or related condition," "unplanned removal or damage to an organ," "conflicting or missing documentation in the patients records," "hospital-incurred trauma," "infection acquired in the hospital and not treated or treated improperly," "adverse blood transfusion reaction," "neurological deficit not present on admission," "adverse drug reaction and medication error" and "newborn with Apgar of 4 or less at five minutes."

Occurrence screening seeks to reduce the occurrence of "disquality" care so that quality assurance becomes disquality prevention.

Screening for generic occurrence criteria has several advantages over other QA methodologies.

1. The workload of physician reviewers is cut dramatically. For example, in place of reviewing all death charts and tissue reports they review only those that vary from the guidelines.
2. Review is concurrent, not retrospective, so that the potential benefit to the patient is immediate.
3. All patients, rather than a sample, are screened.
4. It can be an excellent tool to identify potential liability areas when combined with a complementary risk management program.
5. Criteria that meet specific departmental needs can be developed.
6. "Real" problems as well as patterns of care that raise quality issues are identified.
7. The method is highly efficient. There have been no reported increases in QA staff or costs.
8. It can be applied to physician credentialing.
9. It is not viewed as an infringement on the medical staff because physicians are the cornerstone of the system — they approve the criteria, review and confirm findings of adverse events, and follow up on issues in medical staff and hospital committees.

There is, however, a caveat. In addition to training, orientation, and organizational modifications that need attending before occurrence screening can be initiated, medical staff committees must be fully prepared to deal effectively with a flood of "real" quality problems and concerns. More often than not this will be a new experience for them.

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Strong MD/patient relationship may not preclude a suit

By Emanuel Tanay, MD
Detroit

The following is reprinted, with permission, from the Jan. 24 issue of *Detroit Medical News*, newsletter of the Wayne County Medical Society.

Malpractice litigation exemplifies the universal responsibility imposed upon people with a special relationship to each other. The doctor/patient relationship establishes a bilateral obligation. Some physicians perceive the very principle of malpractice litigation as unacceptable.

If a physician recognizes that he or she has a legal duty in relation to a patient, then it follows that that duty may at times be violated. Malpractice litigation is a dispute over whether or not such a violation has occurred. If an injury to the patient results from such a violation, the legal term for this connection is "proximate cause," which is not identical to the meaning of the medical term "cause." This notion of violation of duty is repugnant to most physicians since it implies misconduct by the physician. Another technical legal term equally capable of arousing intense emotion in the physician is "negligent conduct," or "negligence."

Physicians know that technical medical terms are often misunderstood by their patients; they are less aware that legal clients misinterpret the meaning of technical legal terms. The very term defendant is likely to arouse strong feelings in a physician who, after all, has devoted a lifetime to the creation of a self concept of being a caring healer.

The financial risks associated with being sued, the inconvenience, and the possible impact upon one's reputation are sufficient explanations of the intense emotional reactions which a malpractice lawsuit triggers in a physician. The realistic factors make a malpractice lawsuit quite undesirable; the emotional elements, however, make it unbearable.

A great deal of effort has been expended by physicians to diminish the likelihood of malpractice litigation. Physicians are aware that primary prevention, desirable as it might be, is often unattainable.

Far too little attention has been paid to the reduction of pain and suffering experienced by physicians who have been and who are involved in malpractice litigation. One can never expect a physician to be invulnerable to the emotional impact of being sued by a patient or family. One can, however, significantly diminish the damage resulting from it.

Modern medicine is associated with unexpected disastrous results. The technological age created the expectation that health is produced and maintained by the Health Maintenance Industry. The medical establishment is held responsible for the compensation of damages resulting from the production and maintenance of health. A cardiac arrest, like the explosion of a fuel tank in an automobile, may be associated with injuries. As a matter of social policy, automobile manufacturers and the Health Maintenance Industry are required to provide financial compensation to persons who have suffered unexpected results.

One can argue that imposing this burden upon physicians and other "health care providers" is unfair, and that another mechanism should be devised to deal with this problem. Intense involvement with this social policy issue at the time when one is involved with a malpractice lawsuit is likely to be maladaptive.

Defense lawyers, in the best tradition of advocates and just like plaintiff's lawyers, cater to the legal and emotional needs of their clients. The problem is that the lawyers sometimes achieve good legal results at the price of emotional damage.

It might be in the best interests of the patient who suffered a medical mishap to receive substantial monetary compensation. It is not in the best interests of this person to develop the conviction that his or her physician is a villain, or even worse, that doctors as a group are untrustworthy. The capacity to trust a physician is a valuable asset which deserves protection.

It might be in the best interests of a physician to obtain a vigorous defense in a particular piece of litigation instituted against him or her. It is, however, not in the best interests of the doctor to develop the conviction that his or her patient is simply greedy or is misguided by an unscrupulous lawyer and supported by an unethical expert witness.

The patient who is suing his or her doctor is likely to have some guilt and conflict about such an undertaking. The ambivalence about proceeding legally against one's physician is diminished if the doctor can be seen as evil. Aggressive action against a wrong doer is acceptable even to the timid. The suing patient has a transitory need to distort his or her perception of the defendant physician and of medicine in general. The injured patient acquires an additional burden, namely a paranoid attitude, sometimes euphemistically called righteous indignation.

The physician who has been sued for malpractice suffers a narcissistic injury, the pain of which is lessened by the view that the suing patient is evil. Many defense lawyers carefully nurture the righteous indignation of the defendant physician. An emotionally aroused physician devotes more time and energy to a lawsuit. Furthermore, it is much more gratifying to fight a conspiracy of greedy manipulators, instead of being involved in a controversy with a suffering patient and fellow professionals.

When the righteous indignation of a patient meets the righteous indignation of a physician, the inevitable result is paranoid distortion of reality.

People who are engaged in a holy war, be they plaintiffs or defendants, believe themselves entitled to extraordinary measures. A great deal of distorted testimony occurs in malprac-

Continued on page 271

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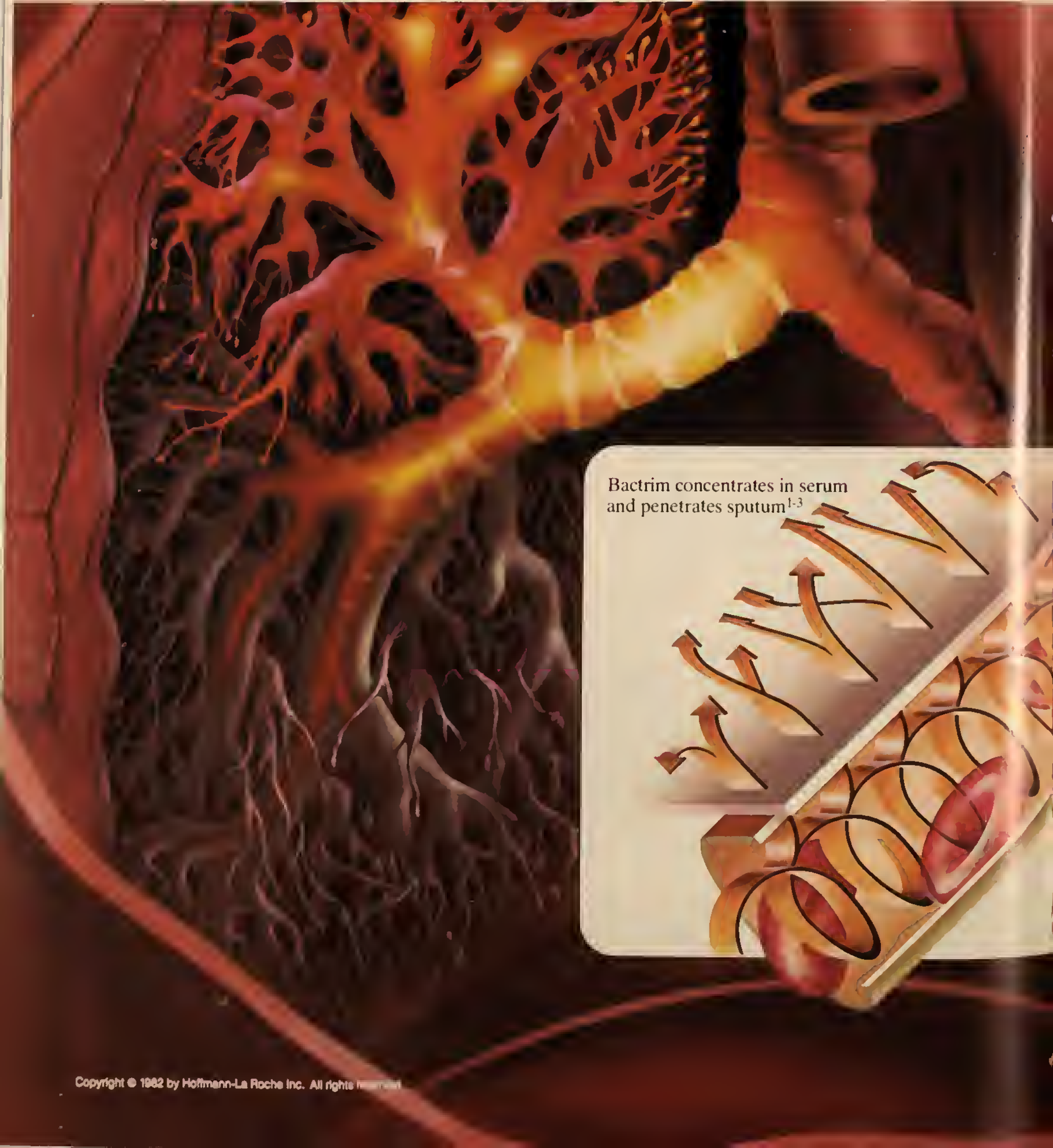

Bactrim concentrates in serum and penetrates sputum[1-3]

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major pathogens of chronic bronchitis*

Bactrim clears sputum of susceptible bacteria

In sputum cultures from patients with acute exacerbations of chronic bronchitis, *H. influenzae* and *S. pneumoniae* are isolated more often than any other pathogens.[4,5] One study of transtracheal aspirates from 76 patients with acute exacerbations found that 80% of the isolates were of these two pathogens.[5]

Bactrim is effective *in vitro* against most strains of both *S. pneumoniae* and *H. influenzae*—even ampicillin-resistant strains. And in acute exacerbations of chronic bronchitis involving these two pathogens, sputum cultures taken seven days after a two-week course of therapy showed that Bactrim eradicated these bacteria in 91% (50 of 55) of the patients treated.[6]

Bactrim reduces coughing and sputum production

In three double-blind comparisons with ampicillin *q.i.d.*, Bactrim DS proved equally effective on all clinical parameters.[7-9] Bactrim reduced the frequency and severity of coughing, reduced the amount of sputum produced and cleared the sputum of purulence.

Bactrim has the added advantages of *b.i.d.* dosage convenience and a lower incidence of diarrhea than with ampicillin, and it is useful in patients allergic to penicillins.

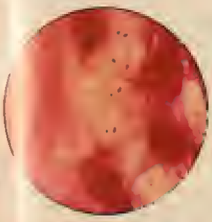
Bactrim also proved more effective than tetracyclines in 10 clinical trials involving nearly 700 patients.[10] Overall clinical condition of the patients, changes in sputum purulence, reduction in sputum volume and microbiological clearance of pathogens—all improved more with Bactrim therapy than with tetracyclines. G.I. side effects occurred in only 7% of patients treated with Bactrim compared with 12% of tetracycline-treated patients. (See Adverse Reactions in summary of product information on next page.)

Bactrim is contraindicated in pregnancy at term and nursing mothers, infants under two months of age, documented megaloblastic anemia due to folate deficiency and hypersensitivity.

Bactrim DS. For acute exacerbations of chronic bronchitis in adults* when it offers an advantage over single-agent antibacterials.

References: **1.** Hughes DTD, Bye A, Hodder P *Adv Antimicrob Antineoplastic Chemother I*/2:1105-1106, 1971. **2.** Jordan GW *et al. Can Med Assoc J 112*:91S-95S, Jun 14, 1975 **3.** Beck H, Pechere JC *Prog Antimicrob Anticancer Chemother 1*:663-667, 1969 **4.** Quintiliani R Microbiological and therapeutic considerations in exacerbations of chronic bronchitis, in *Chronic Bronchitis and Its Acute Exacerbations Current Diagnostic and Therapeutic Concepts;* Princeton Junction, NJ, Communications Media for Education, Inc . 1980, pp 9-12 **5.** Schreiner A *et al Infection* 6(2).54-56, 1978 **6.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ **7.** Chodosh S. Treatment of acute exacerbations of chronic bronchitis: results of a double-blind crossover clinical trial, in *Chronic Bronchitis and Its Acute Exacerbations Current Diagnostic and Therapeutic Concepts. Op cit.*, pp 15-16 **8.** Chervinsky P: Double-blind clinical comparisons between trimethoprim-sulfamethoxazole (Bactrim™) and ampicillin in the treatment of bronchitic exacerbations *Ibid.*, pp. 17-18 **9.** Dullano MJ: Trimethoprim-sulfamethoxazole vs. ampicillin in the treatment of exacerbations of chronic bronchitis *Ibid* . pp 19-20. **10.** Medici TC: Trimethoprim-sulfamethoxazole (Bactrim™) in treating acute exacerbations of chronic bronchitis. summary of European clinical experience *Ibid.*, pp. 13-14

attacks *H. influenzae*—even ampicillin-resistant strains



attacks *S. pneumoniae*

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Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole/Roche)

*Due to susceptible organisms **Please see next page for summary of product information.**

Bactrim™
(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:
Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note.* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.
For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.
For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.
For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.
Also for the treatment of documented *Pneumocystis carinii* pneumonitis.
Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.
Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.
Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.
Pregnancy: Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.
Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.
Dosage: Not recommended for infants less than two months of age.
URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN
Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.
Children. Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.
For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.
ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS.
Usual adult dosage. 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.
PNEUMOCYSTIS CARINII PNEUMONITIS:
Recommended dosage. 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.
Supplied: *Double Strength (DS) tablets*, each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100, Tel-E-Dose® packages of 100; Prescription Paks of 20 and 28. *Tablets*, each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension*, containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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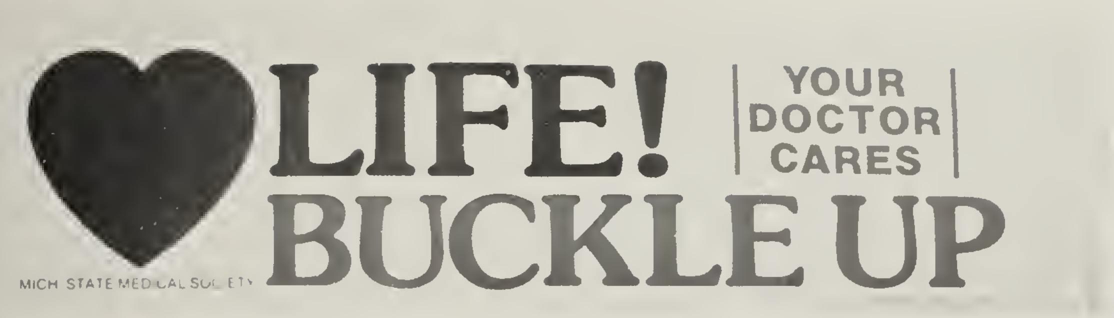

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Please send me	____	100 "Buckle Up" Bumper Stickers	Shipping cost: $1.50
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NEWS

By Sheri W. Greenhoe
East Lansing

Axelrod

Domino

New president of the Oakland Health Education Program (OHEP) is **Robert L. Segula, MD,** Bloomfield Hills. OHEP conducts CME programs in the Oakland area. . . . Physician members of the Michigan Hospital Association Committee on Public Policy and Government are **Leonard Bender, MD,** executive vice president and chief executive officer, Rehabilitation Institute, Detroit; and **Jack Ryan, MD,** president, Detroit-Macomb Hospitals Association. The committee formulates MHA policy concerning issues which influence the delivery of health care or the public health. . . . BCBSM president **Jack McCabe,** is the top elected officer of the merged national Blue Cross and Blue Shield Association. . . . **Frederick W. Hyde, Jr., MD,** Detroit, retired last fall after serving the health care needs of Detroit residents for more than four decades. He had held several major administrative offices at Grace Hospital, and was involved in the development of the Detroit Medical Center in the 1950's. . . . New editor of *Immunology and Allergy Practice,* and president-elect of the American Association for Clinical Immunology and Allergy is **Sidney Friedlaender, MD,** Southfield. . . . Former Brent Hospital Chief of Staff and Trustee, **Henry Schlesinger, MD,** West Bloomfield, was honored recently for more than 35 years of service on hospital committees. Doctor Schlesinger also was lauded by the American Academy of Family Physicians for more than 25 years of membership. . . . New governor of the 54,000-member American College of Physicians is **Arnold R. Axelrod, MD,** West Bloomfield. He is chairman of the Department of Medicine at Sinai Hospital and professor of medicine at WSU. . . . **Martin B. Trotsky, MD,** Southfield, has been appointed to the executive council of the American Academy of Otolaryngolic Allergy for a three year term. . . . President-elect of the Michigan Psychoanalytical Society and founder and chairman of the Michigan Society for Clinical Gerontology is **Bernard Chodorkoff, MD, PhD;** Birmingham. . . . **Samuel Gershon, MD,** was a member of a team of scientists from WSU and the Lafayette Clinic which discovered a chemical abnormality in the brains of people who commit suicide. Their findings were reported in the June 18 issue of *Science.* . . . **Norman Nigro, MD,** and his WSU associates, reported in the July issue of the *Journal of the National Cancer Institute* that a low fat/high fiber diet in combination with specific vitamin supplements may be the best way to prevent cancer of the colon. . . . **Robert Toteff, MD,** Saginaw, is the new vice president of the Michigan Academy of Family Physicians. . . . New president of the Family Health Institute of Michigan is **George A. Dean, MD,** Southfield. . . . **Dong H. Shin, MD, PhD,** Detroit, was guest speaker at the Korean-Japan Joint Meeting of Ophthalmology last fall, and visiting professor at Seoul National University. . . . New member of the Michigan Heart Association board of trustees is **Roger M. Morrell, MD, PhD,** WSU professor. . . . **William R. Darmody, MD,** WSU Associate Professor of Neurosurgery, gave a seminar on head and spine injury at the American College of Emergency Physicians meeting in San Francisco last fall. . . . **Werner U. Spitz, MD,** Detroit was appointed honorary member of the Latin-American Association of Legal Medicine, and was a guest lecturer at the Pan American Symposium of Legal Medicine. . . . **Frank B. Walker, MD,** Grosse Pointe Farms, was appointed to the American Medical Association Council on Long Range Planning and Development. He also was appointed trustee-designate to the American Board of Pathology. . . . **Jeanne M. Lusher, MD** was recently elected to the medical and scientific advisory council of the National Hemophilia Foundation, and appointed chairman of the Foundation's Education Committee. . . . **Allen Sosin, MD,** Farmington, is medical director of Camp Michi-MAC, which encourages asthmatic children to participate in a camping program with non-asthmatic children. . . . **Agustin Arbulu, MD,** Detroit, assumed the general chairmanship of the tri-state Pembine Conference. In addition, he was re-elected governor of the Michigan Chapter of the American College of Chest Physicians for the next three years. . . . **R. Lawrence Kroovand, MD,** Detroit, has been appointed secretary/treasurer of the Michigan Branch of the American Urological Association. He also was elected executive committee member of the American Academy of Pediatrics and president of the Michigan Myelodysplasia Association. . . . Birmingham cardiologist **Donald C. Overy, MD,** received the American Heart Association's Award of Merit recently. He was selected for the national honor "in recognition of dedicated and distinguished service . . ." **Busharat Ahmad, MD,** Marquette, medical advisor to the Upper Peninsula Eye Bank, is president-elect of the association this year and in 1984 will become president of the Eye Bank Association of America. . . . **Ernest Hardaway II, MD,** Hamtramck, native has been appointed as Commissioner of Public Health in the District of Columbia. . . . **Robert H. Gregg, MD,** Detroit Medical Center, has announced his retirement as president and chief executive officer of Children's Hospital after more than a decade in that position. At the request of the Board of Trustees, he will remain with Children's as Executive Director for Special Projects. . . . **Alan D. Perlmutter, MD,** WSU professor, was the first annual J. Hartwell Harrison Visiting Professor of Urology at Harvard Medical School and Brigham and Women's Hospital in Boston recently. . . . **Edward F. Domino, MD,** was recently elected to the council of the American College of Neuropsychopharmacology and was awarded a Certificate for Service with Great Distinction by the US Army Medical Research and Development Command . . . **Jose Limjuco Evangelista, Jr., MD,** Livonia cardiologist and president of the Philippine Medical Association of Michigan, was featured in the February issue of the *APPA/Philippine American Medical Bulletin,* and was pictured on its cover.

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Continued on page 262

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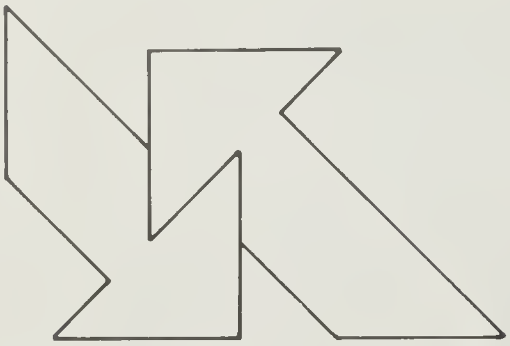
MEETINGS



MSMS, MSMS/A, AMA, and medical assistants

April 21 — "Improving Your Practice in Today's Competitive Climate," an MSMS workshop for established physicians, Lansing Midway Motor Lodge. $55 fee includes lunch, coffee breaks, handouts and "Challenge of the 80's" book. Look for registration forms in *Michigan Medicine* and *Medigram.*

April 21-24 — Medical Assistants State Annual Convention, Plymouth Hilton, Plymouth, contact: Caroline Rich, MSMS headquarters, 517/337-1351.

April 27 — "Improving Your Practice in Today's Competitive Climate," an MSMS workshop for established physicians, Flint Hyatt Regency. $55 fee includes lunch, coffee breaks, handouts and "Challenge of the 80's" book. Look for registration forms in *Michigan Medicine* and *Medigram.*

April 29-May 1 — MSMS House of Delegates, Hyatt Regency, Dearborn, contact: Richard Campau, 517/337-1351.

May 2-3-4 — MSMS/A 57th Annual Convention, Sheraton Inn, Jackson, contact: Caroline Rich, 517/337-1351.

May 18 — "Improving Your Practice in Today's Competitive Climate," an MSMS workshop for established physicians, Southfield, Michigan Inn. $55 fee includes lunch, coffee breaks, handouts and "Challenge of the 80's" book. Look for registration forms in *Michigan Medicine* and *Medigram.*

May 20-21 — AMA Conference on Prevention of Disabling Injuries. Omni International Hotel, Miami, contact: AMA, Division of Personal and Public Health Policy, 535 N. Dearborn, Chicago 60610.

May 25 — "Improving Your Practice in Today's Competitive Climate," an MSMS workshop for established physicians, Grand Rapids Marriott Inn. $55 fee includes lunch, coffee breaks, handouts and "Challenge of the 80's" book. Look for registration forms in *Michigan Medicine* and *Medigram.*

May 26-27 — Annual Gull Lake Conference, MSMS Committee on Maternal and Perinatal Health, MSU Conference Center, Gull Lake, Kalamazoo, contact: Katie Brewbaker, MSMS headquarters, 517/337-1351.

June 1 — "Improving Your Practice in Today's Competitive Climate," an MSMS workshop for established physicians, Ann Arbor Holiday Inn, West Bank. $55 fee includes lunch, coffee breaks, handouts and "Challenge of the 80's" book. Look for registration forms in *Michigan Medicine* and *Medigram.*

June 18-23 — Annual Meeting of the AMA House of Delegates, Marriott Hotel, Chicago, contact: Bruce Ambrose, MSMS headquarters.

June 19-22 — AMA Auxiliary Convention, The Drake Hotel, Chicago, IL, contact: Caroline Rich, 517/337-1351.

July 21-24 — MSMS Council Midsummer Meeting, Deer Lake, Boyne Mountain, contact: Warren F. Tryloff, MSMS headquarters.

Sept. 14 — MSMS Council Meeting (Rescheduled from Sept. 21 to Sept. 14), MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Oct. 27 — MSMS Leadership Conference, Long's Convention Center, Lansing, contact: William Madigan or Kevin Kelly, MSMS headquarters, 517/337-1351.

Nov. 15-17 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters, 517/337-1351.

Nov. 23 — MSMS Council, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Other Meetings

April 20-24 — 1983 Annual Meeting, Society for Research in Child Development, Cadillac Hotel, Detroit, contact: Dorothy H. Eichorn, Tolman Hall, University of California, Berkely, CA 94720, (415) 642-6401.

April 23-26 — 1983 Annual Meeting, Michigan Dental Association, The Westin Hotel, Detroit, contact: Gerri Matelske, 230 N. Washington, Lansing, 48933, (517) 372-9070.

May 17-19 — Silver Anniversary Seminar, 25th Annual Meeting of The Michigan Society for Respiratory Therapy, Hyatt Regency Flint, contact MSRT Program Registration, PO Box 950, 120 W. Saginaw St., East Lansing 48823.

May 19-21 — 1983 Annual Meeting, Michigan Association of Osteopathic Physicians and Surgeons, Inc., Dearborn, contact: D. A. "Tony" Deshaw, 33100 Freedom Rd., PO Box 286, Farmington, 48024, (313) 476-2800.

May 26 — Southwestern Michigan Perinatal Association "Perinatal Potpourri," Western Michigan University, Kalamazoo, contact: Karen Riley, RN, OB Education Coordinator, Memorial Hospital, 2611 Morton Ave., St. Joseph 49085, 616/983-8171.

May 26-31 — American Association for the Advancement of Science, Westin Hotel, Detroit, contact: Ms. Elisabeth Zeutschel, 1101 Vermont Ave. NW, Washington, DC 20005, (202) 842-9530.

June 4-7 — 1983 Annual Meeting, Michigan Optometric Association, Boyne Highlands Inn, Harbor Springs, contact: William D. Dansby, Fifth Floor Capitol Bldg., 115 W. Allegan St., Lansing, 48933, (517) 482-0616.

June 5-9 — 1983 Annual Meeting, American Society of Hospital Pharmacists, Cobo Hall, Detroit, contact: Marilyn Sullivan, 4630 Montgomery Ave., Bethesda, MD 20814 (301) 657-3000.

June 22-24 — 1983 Annual Meeting, Michigan Licensed Practical Nurses Association, Amway Grand Plaza, Grand Rapids, contact: Barbara Wells, 5900 Executive Dr., Lansing, 48910, (517) 882-6657.

June 24 — Annual Meeting, Upper Peninsula Medical Society, Iron

Mountain, contact: Donald J. Jacobs, MD, 1609 Parkview Drive, Iron Mountain 49801.

August 7-11 — 1983 Annual Meeting, National Pharmaceutical Association, Westin Hotel, Detroit, contact: James N. Tyson, PO Box 934, Howard University, Washington, DC 20059, (202) 636-7963.

August 19-21 — 1983 Congress, Michigan Association of the Professions, Sugar Loaf Mountain Resort, Cedar, contact MAP, 1407 S. Harrison Road, Suite 350, East Lansing 48823.

Sept. 6-10 — Association for the Advancement of Medical Instrumentation (AAMI) 1983 Regional Meeting, Detroit, interested participants/cosponsors for 1983 or 1984 meetings should contact: Renee Pietrangelo, AAMI national office, 703/525-4890.

Oct. 6-9 — 1983 Annual Meeting, National Black Nurses Association, Westin Hotel, Detroit, contact: E. Lorraine Baugh, PO Box 18358, Boston, MA 02118, (617) 266-9703.

Oct. 10-14 — 1983 Annual Meeting, National Mental Health Association, Hyatt Regency Dearborn, contact: Molly Mannon, 1800 N. Kent St., Arlington, VA 22209, (703) 528-6405.

Nov. 10-12 — Michigan Association for Health, Physical Education, Recreation & Dance, Hilton Inn, Traverse City, contact: Sanford Dornbos, Eastern Michigan University, Ypsilanti, 48197, (313) 487-0175.

Nov. 11 — 1983 Annual Meeting, American Medical Women's Association, Dearborn, contact: Carol Meyers, 465 Grand St., New York, NY 10002, (212) 533-5104.

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CATEGORY I COURSES

Michigan Medicine each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517)337-1351.

Date: April 25, "The Physician and Hospice Care." Location: Marquette Holiday Inn. **Sponsor:** Michigan Hospice Organization and Michigan Funeral Directors Association. **Cost:** $70— Registration available at the door **Contact:** MFDA, 2420 Science Parkway, Okemos 48864 (517) 349-6786. **Approved for:** 5 hours of Category I Credit from MSU College of Human Medicine.

Date: April 26, "The Physician and Hospice Care." Location: The Chateau, Gaylord. **Sponsor:** Michigan Hospice Organization and Michigan Funeral Directors Association. **Cost:** $70— Registration available at the door **Contact:** MFDA, 2420 Science Parkway, Okemos 48864 (517) 349-6786. **Approved for:** 5 hours of Category I Credit from MSU College of Human Medicine.

Date: April 27, What DRs Need to Know about DRGs. Location: Briarwood Hilton, Ann Arbor. **Sponsor:** Commission on Professional and Hospital Activities. **For:** Chiefs of staff, directors of medical administration, medical directors, physicians involved in PSROs, hospital-based physicians. **Cost:** $175. **Contact:** CPHA— Institute for Professional Development, 1968 Green Rd., PO Box 1809, Ann Arbor, 48106. **Approved for:** 4 hours of Category I Credit.

Date: April 28, "The Physician and Hospice Care." Location: Dearborn Hyatt Regency. **Sponsor:** Michigan Hospice Organization and Michigan Funeral Directors Association. **Cost:** $70— Registration available at the door **Contact:** MFDA, 2420 Science Parkway, Okemos 48864 (517) 349-6786. **Approved for:** 5 hours of Category I Credit from MSU College of Human Medicine.

Date: April 29, "The Physician and Hospice Care." Location: Stouffers Inn, Battle Creek. **Sponsor:** Michigan Hospice Organization and Michigan Funeral Directors Association. **Cost:** $70— Registration available at the door **Contact:** MFDA, 2420 Science Parkway, Okemos 48864 (517) 349-6786. **Approved for:** 5 hours of Category I Credit from MSU College of Human Medicine.

Date: April 29, "Clinical Aspects of Sports Medicine." Location: Western Michigan University. **Sponsors:** Southwestern Michigan Area Health Education Center, and Borgess Hospital. **Cost:** $75. **Contact:** Charles L. Zeller, Jr., MD, Director, Continuing Medical Education, SMAHEC, 1521 Gull Road, Kalamazoo 49001, (616) 388-7877. **Approved for:** 7 hours of Category I Credit.

Date: April 28-29, 12th Annual Critical Care Symposium. Location: Northfield Hilton, 5500 Crooks Road at I-75, Troy. **Sponsor:** Michigan Committee on Trauma, ACS; Michigan Society of Critical Care Medicine; Wayne State University School of Medicine. **Cost:** $150. **Contact:** Theresa Sokol, WSU, Dept. of Surgery, 6-C UHC, 4201 St. Antoine, Detroit 48201. **Approved for:** 12 hours of Category I Credit.

Date: April 30-May 1, International Conference: Empirical Approaches to the Validation of Manipulation. Location: MSU College of Osteopathic Medicine, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **For:** DOs, MDs, physical therapists and others concerned with the effects of manipulative therapy upon back pain. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 14.5 hours of Category I Credit.

Date: April 30-May 1, 28th Scientific Session-Michigan Society of Anesthesiologists. **Location:** Sheraton-Southfield Hotel, Southfield. **Sponsor:** Michigan Society of Anesthesiologists. **Cost:** $60. **Contact:** MSA, PO Box 950, 1305 Abbott Road, East Lansing 48823. **Approved for:** 7 hours of Category I Credit.

Date: May 11, "Dealing with Common Emotional Disorders." Location: Gilmore Center for Health Education, Kalamazoo. **Sponsors:** Southwestern Michigan Health Education Center, and The Upjohn Company. **Cost:** $50. **Contact:** Charles L. Zeller, Jr., MD, Director, Continuing Medical Education, SMAHEC, 1521 Gull Road, Kalamazoo 49001, (616) 388-7877. **Approved for:** 7 hours of Category I Credit.

Date: May 12-13, Phlebotomy Team: Third Annual Spring Conference. Location: The Towsley Center, Ann Arbor. **Sponsor:** U-M Medical School, Office of Continuing Medical Education, Dept of Postgraduate Medicine and Health Professions Education, and Phlebotomy Services Department of Pathology. **Cost:** $175. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 10 hours of Category I Credit.

Date: May 13-15, Michigan Society of Pathologists' May Seminar. Location: Bay Valley Inn, Bay City. **Sponsor:** Michigan Society of Pathologists. **Contact:** Dr. Willys F. Mueller, Department of Pathology, Hurley Hospital, Flint. **Approved for:** 3 hours of Category I Credit.

Date: May 16-20, Advances in Internal Medicine, 11th Annual Spring Update. Location: Towsley Center, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Office of CME, Department of Postgraduate Medicine and Health Professions Education and the Department of Internal Medicine. **Cost:** $475-physician course fee; $295 for physicians-in-training, retired physicians and other health care professionals. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 35 hours of Category I Credit.

Date: May 18, Inflammatory Bowel Disease. Location: Saint John Hospital, 22101 Moross Rd., Detroit 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Surgery. **Cost:** Physicians $90; Residents, fellows, nurses, allied health professionals, and others $35. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education, (313) 343-4877. **Approved for:** 8 hours of Category I Credit.

Date: May 20, 13th Annual Cardiology Symposium. Location: Borgess Medical Center. **Sponsors:** Southwestern Michigan Area Health Education Center, and Borgess Medical Center. **Cost:** $85. **Contact:** Charles L. Zeller, Jr., MD, Director, Continuing Medical Education, SMAHEC, 1521 Gull Road, Kalamazoo 49001, (616) 388-7877. **Approved for:** 7 hours of Category I Credit.

Date: May 23-25, Clinical Chemistry and Immunology 5th Annual Spring Conference. Location: The Towsley Center, Ann Arbor. **Sponsor:** U-M Medical School, The Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, and The Department of Pathology. **Cost:** $245. **Contact:** Office of Continuing Medical Education, The Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 18.5 hours of Category I Credit.

Date: May 23-27, Head and Neck Oncology. Location: U-M Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School, The Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, and The Department of Otolaryngology — Head and Neck Surgery. **Cost:** $750. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 43 hours of Category I Credit.

Date: June 1-3, Current Topics in Blood Banking: 10th Annual Symposium. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Medical School, Office of CME, Department of Postgraduate Medicine and Health Professions Education and the Department of Pathology. **Cost:** $195-physician course fee, $130- physician-in-training, retired physicians or other health care professionals. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 12.5 hours of Category I Credit.

Date: June 6-7, Current Concepts in Clinical Microbiology Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Medical School, Office of CME, Department of Postgraduate Medicine and Health Professions Education and Clinical Microbiology Laboratory Department of Pathology. **Cost:** $195-physician course fee; $135-other health care professionals. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor, 48109. **Approved for:** 13 hours of Category I Credit.

Date: June 13-17, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Medicine, MSU, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine, Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48823 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: June 15, Geriatrics and Family Practice, Medical and Ethical Decision Making. Location: Saint John Hospital, 22101 Moross Rd., Detroit 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Family Practice. **Cost:** Physicians $90; Residents, fellows, nurses, allied health professionals, and others $35. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education, (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: June 16, First Annual Research Day/Paper Competition. Location: Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All attending physicians, residents and medical students in the Kalamazoo medical community only. **Contact:** Judith B. Willis, MA, PA-C, Director, Research & Regional Medical Education, SMAHEC, 616-383-6360 or 383-7363. **Approved for:** 4 hours of Category I Credit.

Date: June 16-17, Clinical Laboratory Computers: Symposium 1983. Location: U-M, The Towsley Center, Ann Arbor. **Sponsor:** U-M Medical School, The Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, and the Department of Pathology. **Cost:** $245. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 12 hours of Category I Credit.

Date: June 16, 17 and 18, Medicolegal Investigation of Death. Location: Hotel Pontchartrain, Detroit. **Sponsor:** Wayne State University School of Medicine, Department of Pathology and Wayne County Medical Examiner's Office. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 4201 St. Antoine, 4H UHC, Detroit 48201, (313) 577-1180. **For:** Medical examiners, pathologists engaged in medicolegal work, coroners, and other interested individuals. **Approved for:** 19 hours of Category I Credit.

Date: June 16-18, 34th Annual Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Club, Gaylord. **Sponsor:** Michigan Committee on Trauma, ACS; Michigan Society of Critical Care Medicine; WSU School of Medicine. **Cost:** $75. **Contact:** B. E. Henig, MD, PO Box 605, Grayling 49738. **Approved for:** 12 hours of Category I Credit.

Date: June 19-24, Nineteenth Annual Northern Michigan Summer Conference. Location: Hilton Shanty Creek, Bellaire. **Sponsor:** U-M Office of CME, Dept. of Postgraduate Medicine and Health Professions Education. **Cost:** $395. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 20 hours of Category I Credit.

Date: June 21-23, Real-time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Department of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: July 10-13, Intermediate Course on Craniosacral Technique. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: July 18-19, Developing, Marketing, and Managing Conferences: Making It In Tough Times. Location: The Towsley Center, Ann Arbor. **Sponsor:** The University of Michigan Medical School, The Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education. **For:** Those who will develop/manage conferences and need to know how to do it more effectively and economically, whether for universities, hospitals, professional societies, businesses, or hotels. **Cost:** $345. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 12.5 hours of Category I Credit.

July 28-29, Coller Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City. **Sponsor:** Munson Medical Center. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th & Madison Sts., Traverse City 49684 (616) 947-6140, Ext. 146. **Approved for:** 9 hours of Category I Credit.

Date: August 15-19, Tutorial on Direct Action Thrusting. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: September 12-16, Basic Muscle Energy Tutorial. Location: Kellogg Center (MSU), East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Sept. 29-Oct. 2, Sixth Annual Course in Diagnostic Ultrasound. Location: The Towsley Center, U-M Medical School, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **Contact:** Office of Continuing Medical Education, Towsley Center Box 057, University of Michigan Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 24 hours of Category I Credit.

Date: Sept. 30-Oct. 2, Tutorial on Myofascial Release Technique. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: Oct. 3-7, Advanced Muscle Energy Tutorial (above diaphragm). Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

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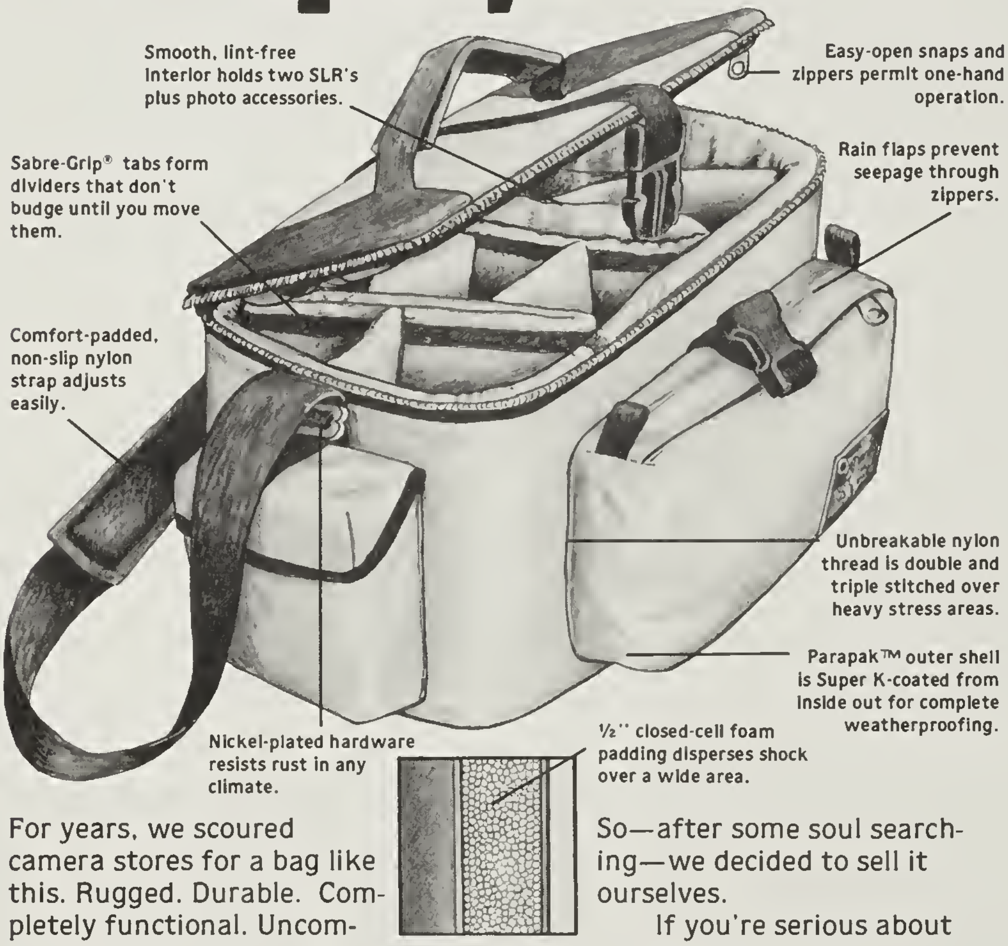
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DEATHS

Francis W. Dwyer, MD
West Bloomfield

Francis W. Dwyer, MD, West Bloomfield, died January 27 at the age of 82. Doctor Dwyer earned his MD at Loyola University Stritch School of Medicine in 1929. He served his internship at Chelsea Navy Hospital in Massachusetts. Doctor Dwyer had been affiliated with Providence Hospital in Southfield for more than 40 years, and president of its medical staff in 1960. A retired captain in the US Navy, Doctor Dwyer served aboard the USS Charles Carroll as chief medical officer during the Normandy Invasion. He also served as chief of surgery at the US Naval Hospital in Great Lakes, Illinois from 1944 until 1945. Past president of the Detroit Chapter of the American College of Surgeons, he was a staff member at Eloise and Old St. Mary's hospitals.

Louis D. Gomon, MD
Palm Beach, Florida

Louis D. Gomon, MD, Saginaw ophthalmologist for more than 40 years, died January 10. He was 76. Doctor Gomon earned his medical degree at the University of Michigan in 1929, then served his residency at Harper Hospital. He continued his medical education at Wills Eye Hospital in Philadelphia. Doctor Gomon had been on staff at St. Luke's, Saginaw General, and St. Mary's hospitals. He was named "Outstanding Physician of the Year" at St. Luke's in 1961. Doctor Gomon was a past president of Saginaw County Medical Society, and was a fellow of the American College of Surgeons; a diplomate of the Board of Ophthalmology; a member of the Select Service Board of Ophthalmology; the Examining Board of the American College of Surgeons; the American Association of Ophthalmologists; the National Scientific Medical Society; the American Academy of Ophthalmology and Otolaryngology, and an active member of the AMA.

Toufic E. Haddad, MD
St. Louis

Toufic E. Haddad, MD, died December 25 at the age of 59. Doctor Haddad was a native of Lebanon, and earned his MD in 1945 from the

American University of Beirut. He continued his study of medicine at the University of Edinborough in England. Doctor Haddad was affiliated with Gratiot Community Hospital in Alma, and Central Michigan Community Hospital in Mount Pleasant. During the Korean Conflict, Doctor Haddad was a lieutenant in the US Navy Medical Corps, and was a fellow in the Royal College of Surgeons.

Michael M. Levin, MD
Southfield

Michael M. Levin, MD, Southfield, died January 2 at the age of 83. Doctor Levin was born in Lithuania, and received his medical degree from the University of Michigan in 1926. Doctor Levin maintained a cardiology and internal medicine practice for more than 50 years, and was on staff at both Sinai and Grace hospitals. He retired from active practice six years ago. During World War II Doctor Levin served as a Captain in the US Army Medical Corps.

Donald W. Martin, MD
San Diego, California

Donald W. Martin, MD, formerly of Ypsilanti, died January 11. He was 76. Doctor Martin, former chief of staff at Beyer Memorial Hospital, graduated from the University of Michigan Medical School in 1934. He joined the Beyer Hospital staff in 1941, and also served as chief of surgery and as a member of the executive committee, at various times during his career there. Doctor Martin was granted honorary medical staff membership at Beyer in 1977, after his retirement, in recognition of his long and dedicated service. A past president of Washtenaw County Medical Society, he moved to San Diego in 1980.

George R. Schneider, MD
Grand Rapids

George R. Schneider, MD, Grand Rapids anesthesiologist, died January 27. He was 63. Doctor Schneider earned his MD from Ohio State University in 1944, then served in the US Army Medical Corps as a commanding officer at a prisoner of war hospital in Italy. He was a past president of the Michigan Society of Anesthesiology and the Associated Anesthesiologists of Grand Rapids. Doctor Schneider was a diplomate of the American Board of Anesthesiology, a fellow of the American Board of Anesthesiologists, and a member of the International Anesthesia Research Society and the Michigan Society of Anesthesiologists.

George D. Shaw, MD
Three Rivers

George D. Shaw, MD, Three Rivers surgeon, died February 20 at the age of 79. Doctor Shaw graduated from Rush Medical College of Chicago in 1926. He served an internship at Butterworth Hospital, then became a flight surgeon with the US Air Force during World War II. Doctor Shaw was on the staffs of Borgess and Bron-

Continued on page 270

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DEATHS/*Continued*

son hospitals of Kalamazoo, and of Three Rivers Hospital. He had been chief of staff several times at the latter. Doctor Shaw and an associate were the founders of Three Rivers Medical Clinic.

Ching-Shiang Wang, MD
Milan

Ching-Shiang Wang, MD, Milan, died January 24. He was 45. Doctor Wang had practiced family and internal medicine in Milan for the past 10 years. A native of Taiwan, Doctor Wang earned his MD in 1963 from National Taiwan University. He also held a PhD degree in physiology. Before becoming affiliated with Saline Community Hospital, Doctor Wang had maintained a private practice in Toronto.

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LAWSUITS/*Continued*

tice cases as the result of righteous indignation.

The short term opportunistic goals of certain plaintiff and defense lawyers contribute to the emotional crisis of malpractice litigation.

The physician and the patient have a relationship which is likely to be disrupted or destroyed by an unexpected bad result. Malpractice litigation is analogous to divorce litigation. Very few people retain the belief that hostility in matrimonial litigation implies an absence of strong feelings during the marriage. Strong feelings during the marriage are likely to lead to strong feelings during the resolution phase of the marriage.

Physicians are being told that a strong positive doctor-patient relationship diminishes the likelihood of malpractice litigation. Neither experience nor psychodynamic understanding supports such a view. Good doctor-patient relationships are highly desirable for a variety of reasons; malpractice prevention is not one of them. The anger of a disappointed patient, like that of a disappointed lover, is directly proportional to the intensity of the pre-existing feelings.

Malpractice litigation has been viewed far too long in purely economic terms. The well-being of patients and physicians requires a psychiatric exploration of malpractice vicissitudes.

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PRESIDENT'S PAGE

Doom and gloom or challenge of the 80's?

Donald K. Crandall, MD
MSMS President-elect

This month, MSMS President James H. Tisdel, MD, gives space in his column to MSMS President-elect Donald K. Crandall, MD, Muskegon, who will take office at the 1983 MSMS House of Delegates Meeting April 29-May 1 in Dearborn.

You don't have to be a prognosticator or futurist to know that the practice of medicine is undergoing significant change at an ever-increasing rate.

The competitiveness of the international economy is placing a limit on the resources available for health care in this country. A surplus of physicians is projected for the immediate future. The federal government is in the process of deregulation of the health care industry. A pro-competition health care model is emerging that will affect physicians, hospitals and paramedical personnel. Numerous new types of health care "delivery systems" are being implemented around the country.

Economists point to the above facts as heralding the doom of the practice of medicine. But while the practice of medicine is certainly undergoing significant and rapid change, rather than being the death knell of our profession, this change could be our greatest challenge — the Challenge of the 80's.

Trend-setters

Physicians have two choices. One is to merely accept the future trends as inevitable; the other is to prepare for the future with an eye to directing it to the greatest good for our patients and our profession.

There are four ways we can position ourselves for the coming future. The first is prediction. We can study trends from around the country to know what to expect in our area. Second is to develop contingency plans to react to these trends. The third is to work collectively and cooperatively with those affected by the changes and to develop a blueprint that is acceptable. The fourth strategy is to be flexible so that we are able to accomodate these trends.

Our times hold out chances for physicians to take initiative and leadership. We can set the trends. Your state medical society is offering you a splendid opportunity to learn how best to make these moves through its new series of seminars and materials on "Meeting the Challenge of the 80's."

You have seen the articles in the March-November, 1982, issues of *Michigan Medicine*. They were a preview of the types of information to be offered to every MSMS member in the seminars premiering this month.

I am particularly excited about the seminars, as they offer the opportunity for MSMS to speak on a regional, local and individual level to help each MSMS member make the right choices for success in our uncertain future. These seminars will feature presentations by expert speakers on marketing, practice management, financial management, competing forms of health care professionals and the general public.

Seminars ahead

Six seminar/workshops are scheduled around the state as follows:

April 13, Kalamazoo Sheraton
April 21, Lansing Midway Motor Lodge
April 27, Flint Hyatt Regency
May 18, Southfield Michigan Inn
May 25, Grand Rapids Marriott
June 1, Ann Arbor Holiday Inn, West Bank

I feel this program is one of the most important activities of MSMS today.

As my year in office progresses, I plan to write several columns on the challenges and the opportunities presented by the changes in medical practice confronting us.

I believe that through sharing our knowledge and helping each other to meet these challenges, we can be assured physicians will continue their leadership role in the delivery of medical care.

These may be the most challenging times for our profession, but with the help of all of our membership, these could also be the most exciting and rewarding times.

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References: 1. Kales A *et al: J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **4.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **5.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Kales JD: *Pharmacol Physicians 4*:1-6, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*:25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

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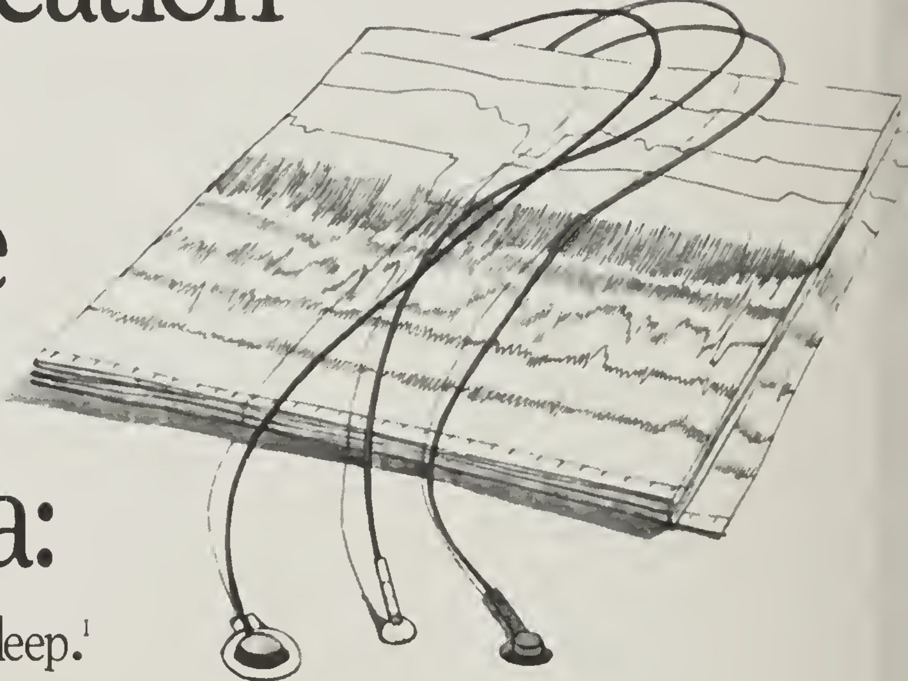

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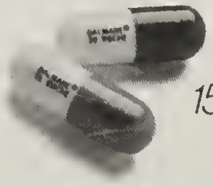

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Vol. 82, No. 20 April 21, 1983
Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

DOCTOR CRANDALL TO BE INSTALLED AS MSMS PRESIDENT

Muskegon surgeon Donald K. Crandall, MD, will be installed April 30 as MSMS president during the 1983 MSMS House of Delegates meeting at the Hyatt Regency Dearborn. Doctor Crandall will succeed James H. Tisdel, MD, Port Huron obstetrician-gynecologist. The annual meeting will include the election of other key MSMS officers including president-elect, speaker, Council chairman, secretary and treasurer. In addition, 225 seated delegates and alternates will set policy by voting on approximately 70 resolutions for MSMS action. Michigan physicians who have been in practice for 50 years will receive pins, and MSMS will honor physician presidents of national medical organizations and state non-medical organizations.

Highlights of the House of Delegates meeting will include the annual luncheon of the Michigan Doctors Political Action Committee. Speaker of the Michigan House of Representatives Gary M. Owen (D-Ypsilanti), and Chairman, Senate Committee on Health and Social Services, Sen. Patrick McCollough (D-Dearborn), will address the MDPAC group. Another special feature will be a forum on the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA), scheduled at 1:30 p.m. April 30.

JUDGE RULES HHS IMPROPERLY SET INFANT RULES

An AMA mailgram April 18 to MSMS announced that Federal District Judge Gesell, of Washington, DC, ruled April 14 that the Department of Health and Human Services acted improperly in promulgating its rule regarding discrimination against handicapped infants. The court ordered the department to withdraw the rule, an action sought by a brief the AMA filed in the case. HHS has announced that it intends to appeal the ruling immediately.

MDPH DIRECTOR GLORIA SMITH TO MEET WITH MSMS

New Michigan Department of Public Health Director Gloria Smith was scheduled to describe her plans for a major study on the effects of dioxin on human health when she met April 20 with members of the MSMS Liaison Committee to the MDPH. Following her appearance before the committee, she was to be feted at a get-acquainted reception at MSMS headquarters. The MSMS committee that day also was to comment on an MDPH draft paper on the role of local health departments in delivery of primary care, and to hear a description of the MDPH disaster response program.

SOME PPSP PATIENTS HAVE NO MD SPONSORS

As of March 24, a total of 15,339 Medicaid recipients were enrolled in the Physician Primary Sponsor Program in Wayne County. At the same time, 1,493 cases were pending, primarily because the physician of those persons' choice had yet to sign a sponsor contract. If those physicians do not sign contracts, their patients will be asked to choose another physician or HMO.

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PUBLIC SAYS MDs' FEES HIGH, DEDICATION UP

The general public, according to an AMA survey recently received by the MSMS Bureau of Economics, has improved its opinion since 1955 of physicians' availability in an emergency, interest in and dedication to patients, and time spent with patients. In contrast, the public support for physicians' fees and incomes shows a substantial decline. The findings suggest that negative public opinion toward physicians' fees and incomes will pose a major challenge to organized medicine in the future.

DOCTOR CRANDALL SEEKS AMA POST; DOCTOR WALKER NAMED

Donald K. Crandall, MD, MSMS president-elect, has been nominated by the AMA Board of Trustees to run for a position on the AMA Council on Medical Service at the annual meeting of the AMA House of Delegates June 19-23. Frank B. Walker II, MD, vice chair of the MSMS delegation to the AMA House, was reappointed by the AMA Board to the Long Range Planning and Development Council.

REMINDER: TEFRA SEMINARS, MEDICAL STAFF MEETING

Michigan physicians who wish to know more about the impact of the Tax Equity and Fiscal Responsibility Act (TEFRA) have an opportunity to learn at two seminars scheduled next month by MSMS. The program and registration forms for the seminars, scheduled May 18 and 19 in Southfield and Lansing, respectively, appeared in the April 14 Medigram. Also in that issue were the program and a registration form for the May 19 MSMS Medical Staff Relations Conference in Lansing. TEFRA also will be the subject of that conference, as well as legal aspects of closed vs. open medical staffs.

CAPSULES

Willard Stawski, MD, Grand Rapids general surgeon, will visit Lansing April 28 as part of the MSMS Physician Legislative Network. Doctor Stawski will meet with Rep. Victor Krause, Sen. Paul Henry, Sen. Dick Posthumus and Rep. Vernon J. Ehlers. . . . Officers of the Michigan Council on Graduate Medical Education are continuing in their posts after reelection at the MCGME annual meeting in March. They are President W. Donald Weston, MD; Vice President Carl A. Gagliardi, MD; Secretary Philip Adler, DO, and Treasurer Gerson Cooper.

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Vol. 82, No. 20 April 21, 1983

Vol. 82, No. 21 April 28, 1983

Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

HOUSE OF DELEGATES TAKES ACTION ON 67 RESOLUTIONS

Activities at the 1983 MSMS House of Delegates meeting April 29-May 1 will be winding down as most members read this newsletter. MSMS delegates will have set policy for the coming year.

Resolutions going before the delegates call for repeal of the Public Health Code provisions mandating assessment of physicians' continued competence, for home health care cost awareness, for opposition to legislation designed to control PPOs, for opposition to widespread establishment of DRG-based reimbursement, for applying part of physicians' relicensure fees toward a salary for a Board of Medicine executive secretary. These are but a few of the 67 resolutions proposed.

Among those to be honored are approximately 30 members of the Class of 1933 who will be on hand to accept 50-year pins. Flag awards will go to Michigan physician presidents of non-medical organizations. They include Vernon V. Bass, MD, Saginaw, Michigan Association of the Professions; Gilbert B. Bluhm, Detroit, Michigan Chapter, National Arthritis Foundation; R. Lawrence Kroovand, MD, Detroit, Michigan Myelodysplasia Association; Robert D. Sparks, MD, Kellogg Foundation, and Louis R. Zako, MD, Dearborn Heights, Michigan Health Council. National Presidents Awards will go to William S. Jones, MD, Allen Park, Civil Aviation Medical Association; Gerald A. O'Connor, MD, Ann Arbor, American Orthopedic Society for Sports Medicine, and E. Emrick Szilagyi, MD, Detroit, Society of Vascular Surgery.

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Look for a complete summary of House of Delegates activities in the May 5 Medigram.

SPEAKER NAMES LEGISLATIVE COST COMMITTEE

Speaker Gary Owen this week announced formation of an ad hoc committee to formulate House of Representatives actions on health care cost containment. Matthew McNeely (D-Detroit), chairman of the House standing Committee on Insurance, will chair the ad hoc group. Other committee members are Reps. Richard Fitzpatrick (D-Battle Creek), also a member of the Insurance Committee; David Hollister (D-Lansing), chairman of the subcommittee on social services of the House Appropriations Committee; Jeffrey Padden (D-Wyandotte), member of the House Public Health Committee; Donald VanSingel (R-Grant), member of the Insurance Committee, and Victor Krause (R-Rockford), member of the Public Health Committee. A corresponding committee is expected to be named in the Senate.

INSIDE THIS ISSUE

Unraveling the mysteries of TEFRA, the Tax Equity and Fiscal Responsibility Act of 1982, will be easier for MSMS members attending the programs described inside. One is just for medical staff leaders; the other (planned in two locations) is for all interested members. Register today!

MICHIGAN STATE MEDICAL SOCIETY

Tax Equity Fiscal Responsibility Act of 1982 (TEFRA) and The Practicing Physician

TEFRA, SECTION 108, regulations for provider based physicians will rework the Medicare Program and have significant financial consequences for many physicians.

The MSMS Bureau of Economics is scheduling two seminars to aid physicians in understanding **TEFRA**. The seminars will be held on Wednesday, May 18 at 1:30 p.m. at the Sheraton-Southfield, Detroit and Thursday, May 19 at 1:30 p.m. at Long's Convention Center, Lansing.

The program will be a discussion of the need to change contractual relationships between hospital-based physicians and their institutions, as well as a practical discussion of how these changes will affect reimbursement for all hospital-based physicians.

Speakers will include:

- **Michael D. Gibson, JD,** Kerr, Russell and Weber, Detroit
- **Thomas J. Herrmann, MD,** Associate Dean of Clinical Affairs, College of Human Medicine, Michigan State University
- **Lawrence A. Manson, JD,** Wood, Lucksinger & Epstein, Chicago
- **George Nicholson, CPA,** Partner, Arthur Anderson Company, Inc.

Also included in the seminar will be a review on the recently enacted **DRG Prospective Reimbursement System** for Medicare and its impact.

- -

REGISTRATION

NAME________________________________ **SPECIALTY**__________________

ADDRESS____

____

May 18 - Southfield___ May 19 - Lansing___

Registration Fee: $25 includes a specially prepared workbook and a reception following the seminar. Mail Check and Registration Form To: **TEFRA** Conference, Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48823. For more information, please contact Deborah Zannoth at 517-337-1351.

MICHIGAN STATE MEDICAL SOCIETY
MEDICAL STAFF RELATIONS CONFERENCE

May 19, 1983
Long's Convention Center
Lansing, Michigan

PROGRAM

8:30 a.m. **Registration**

9:00 **Opening Comments** - Gary D. Maynard, MD, Chairman, Medical Staff Relations Committee

9:15 **Legal Briefing on Open vs. Closed Medical Staffs** - A. Stewart Kerr, JD, MSMS Legal Counsel; J. Kay Felt, JD, Dykema, Gossett, Spencer, Goodnow & Trigg

10:30 **Questions and Answers**

Break

11:00 **Sharpening Criteria for Admission to Medical Staffs/Manpower Budgeting/Avoiding Adversary Roles/Exclusive Contracts** - Robert W. Black, MD, Chief-of-Staff, Harper-Grace Hospitals

11:45 **Questions and Answers**

12:00 **Luncheon**

1:30 p.m. **Tax Equity Fiscal Responsibility Act of 1982 (TEFRA)**

The afternoon session will be a presentation of changes brought about by the recently enacted TEFRA regulations.

The program will be a discussion of the need to change contractual relationships between hospital-based physicians and their institutions, as well as a practical discussion of how these changes will affect reimbursement for all hospital-based physicians.

Speakers will include:
- Michael D. Gibson, JD, Kerr, Russell and Weber, Detroit
- Thomas J. Herrmann, MD, Associate Dean of Clinical Affairs, College of Human Medicine, Michigan State University
- Lawrence A. Manson, JD, Wood, Lucksinger & Epstein, Chicago

5:00 **Reception**

- -

Registration

Please print or type:

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HOSPITAL:____

ADDRESS:____________________________ **CITY/ZIP**__________________

Registration Fee: $25 includes luncheon (Please make check payable to Michigan State Medical Society). Mail Check and Registration Form To: Medical Staff Relations Conference, Michigan State Medical Society, P.O. Box 950, East Lansing, MI 48823. For more information, please contact William Madigan at 517/337-1351

MDPH DIRECTOR ASKS MSMS SUPPORT OF CANCER BILL

The Michigan Department of Public Health Director asked the MSM Liaison Committee with the MDPH April 20 for support of current legislation for a statewide cancer registry. Such a registry, Gloria Smith, PhD, told the committee, is a long-range goal of the MDPH task force on the effects of dioxin upon human health. She was pleased with an MSMS offer to publish progress reports of the task force in Michigan Medicine.

AMA RESPONDS TO MSMS REACTION TO JCAH LANGUAGE

MSMS objection to language in the proposed new manual of the Joint Commission on Accreditation of Hospitals has helped the AMA to change its official stance on the manual. That is according to AMA Executive Vice President James H. Sammons, MD, who has just reported recent actions of the AMA board regardin the revised JCAH manual. The board April 8 confirmed principle set March 22 by the AMA Commissioners to the JCAH for future drafts of the medical staff chapter of the manual. The AMA principles call for continued use of the term "medical staff," and for deleting references to dentists, podiatrists, oral surgeons, and other limited licensed practitioners in the medical staff chapter. Previously, the AMA had granted approval of the much broader term, "organized staff" in place of "medical staff." Physicians in several states, including Michigan, objected strongly to the AMA's acceptance of the "organized staff wording. In late July the JCAH committee will review a new draft similar to that approved by the AMA Board of Trustees. No final action on the medical staff standards section is expected before the August meeting of the JCAH commissioners.

CAPSULES

The 38,000 licensed practical nurses in Michigan will celebrat LPN Day May 5. At the same time, over 65,000 registered nurse in Michigan will celebrate Michigan Nurse Week May 1-7 and National Nurses Day May 6. These special days provide members o the medical profession with an opportunity to hail their fello hard-working professionals. . . . Coming MSMS committee meetin include those of Public Service May 11, Planning Committee for 1983 MSMS Annual Scientific Meeting May 11, CME Accreditation May 12, Concerns of Women Physicians May 18 and State Legislation and Regulations May 19. All are at MSMS headquarters.

MEDIGRAM

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East Lansing, Michigan 48823

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Vol. 82, No. 22 May 5, 1983

Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

JUN 22 1983

Doctor Crandall installed; Doctor Zako elected

Some of the most dramatic moments of the 1983 MSMS House of Delegates meeting came with the races for AMA delegates' and alternate delegates' positions. This year, both groups were expanded, due to AMA membership growth in Michigan. Results of those elections follow below.

Dearborn Heights family physician and former MSMS Council Chairman Louis R. Zako, MD, is the new MSMS president-elect. Doctor Zako also is chairman of the MSMS Committee of Specialty Society Presidents and of the MSMS Committee on Risk Management.

Installed as MSMS president is Donald K. Crandall, MD, Muskegon general surgeon. He succeeds Port Huron obstetrician-gynecologist James H. Tisdel, MD. In his installation address, Doctor Crandall asked his colleagues to combine medcine's high technology systems with a "high touch" human approach. "We must learn to balance the material wonders of technology with the spiritual demands of our human nature," he said. "We will be the buffer between technology and patient."

Re-elected speaker of the MSMS House of Delegates is Gerald H. Mandell, MD, Detroit pathologist. Re-elected vice speaker is Robert D. Burton, MD, Grand Rapids otolaryngologist.

(Continued on page four)

MSMS delegates elect first woman councilor

MSMS delegates made history at their 1983 annual meeting April 29-May 1 in Dearborn. They elected the first woman to the MSMS Council. She is Marguerite Shearer, MD, Ann Arbor general practitioner. The delegates also took the first steps to change the name of the MSMS executive body from The Council to the Board of Directors.

In other major actions, the delegates:

- Okayed a general statement outlining appropriate functions of a preferred provider organization, and 11 guidelines physicians may use in choosing whether or not to participate in a PPO. PPOs, says the statement, should promote fee for service medicine, balance the marketing advantage of other financial mechanisms and encourage innovations to control health care costs.

- Moved to support pending legislation providing members of the Michigan Board of Medicine with immunity or indemnification from litigation resulting from their board work. They also resolved to work with the legislature to enhance the board's staff.

- Resolved to inform the legislature there is no good existing mechanism to assess physicians' continued competency, and to seek amendments to the Public Health Code to delete requirements for such a system.

- Insisted that any hospital requirement for mandatory professional liability insurance must be mutually agreed upon by the hospital and its medical staff.

- Adopted a policy encouraging local medical societies to offer medical care for reduced or deferred payment to unemployed workers and their families, and to seek alternatives to insure that medical care be available for those persons handicapped by unemployment and without health insurance benefits.

- Approved of modifying the Physicians Review Organization of Michigan (PROM) to assure the active involvement and participation of the Michigan Association of Osteopathic Physicians and Surgeons in all peer review activities.

Following are highlights of the delegates' actions:

ECONOMICS

Opposed billing practices which will result in any diversion of doctor-generated income from doctors.

Supported the general principle of equal payment for services delivered equally by hospital free-standing facilities and by physicians' offices, unless the hospital facilities can be shown to render unique services not otherwise available.

Continued support of the principle of one statewide professional reimbursement schedule, and resolved to ask Blue Cross Blue Shield of Michigan to end the freeze on professional reimbursements in southeastern Michigan.

Opposed any legislation to regulate PPOs, and also opposed any legislation which would further enhance the ability of any single organization to dominate the health care delivery market. They took the latter action in the face of pending legislation to allow BCBSM to form its own PPOs.

Asked the Council to evaluate and develop recommendations concerning the effects of diagnostic-related group reimbursement systems on both hospitals and physicians.

MEDICO-LEGAL

Agreed to send a second notice to MSMS members who have neglected to respond to the application for relicensure sent out by the Board of Medicine for 1983; and counseled the MSMS Committee on Membership Recruitment and Retention to consider a program of local contacts for members and non-members who have not yet renewed their licenses.

Moved to request the legislature to restore funding to public mental health hospitals to return to previous levels of care, to seek increased funding for psychiatric research, and to support Michigan Psychiatric Society efforts to assure adequate treatment in public mental health facilities.

Resolved to develop proposals to appropriately modify the Michigan Mental Health Cod to make involuntary hospitalization more rapidly accessible.

Decided to try to monitor the decisions of judges regarding professional liability.

Called for continued emphasis and information from MSMS on how physicians may successfully market their practices.

Moved to seek legislation that would hold harmless physicians immunizing patients according to law, should there be a maloccurrence not due to negligence.

Urged implementation of statutes which require health and human services providers t report cases of elderly abuse and neglect; with immunity to be granted to those providers.

Voted to seek legislation to protect Michigan citizens from unqualified practitioners of obstetrics.

Apportioned the enlarged Michigan delegatio to the AMA (due to increased AMA membership in Michigan) as follows: seven outstate delegates, four Wayne County delegates; seven outstate alternate delegates, three Wayne County alternates, and one alternate from either the resident or student sections.

SOCIAL ISSUES

Reaffirmed support of the MSMS Program to Assist Impaired Physicians and urged county societies and individual physicians to become involved, "so that troubled physicians . . . can be promptly identified and rehabilitated."

Vowed to educate physicians, legislators an public of the dangers of swimming, and the use of electric power in home and workplace

Called on physicians to learn the cost of home health care before requesting it for their patients, to personally interview patients periodically to determine continued need for such care; and called on MSMS to raise physicians' awareness of the evaluation and costs of home health care programs

Commended Gov. Blanchard for maintaining the state's psychiatry residency programs in this time of large budget cuts.

Approved continuation of the MSMS Public Relations Program.

Reaffirmed that physicians should inform their patients of inappropriate medical services they may be receiving.

Opposed promulgation and provision of free-standing clinical education by hospitals in our state to American citizens enrolled in medical schools abroad. ("Freestanding" was defined as a clinical education that is offered without the supervision of a medical school in the U.S. or Canada.)

PUBLIC HEALTH

Directed legal counsel to consider filing an amicus curiae brief in support of injunctions on regulations that would require notification of parents of minors receiving contraceptive advice from federally-funded clinics.

Encouraged members to learn more about the public health department's recommendations for addressing the problem of the infant mortality rate in Michigan; and resolved to support perinatal education services to area hospitals and clinics where these services are not readily available.

Requested the state to resume full payment of physicians' fees for general assistance patients.

Supported investigative efforts to determine the extent of toxic chemical contamination of Michigan water supplies.

Supported current insurance companies' policies to raise auto insurance rates for persons convicted of driving under the influence of alcohol.

Called on MSMS to assume a leadership role in developing guidelines for bioethicists, and to work closely with them.

Supported the American Academy of Pediatrics' opposition to federal regulation requiring all pediatric wards, nurseries and outpatient clinics to undertake 24-hour investigation of any case where medical care allegedly is being withheld.

Decided to petition state officials and the legislature against any state agency having the power to develop a closed drug formulary which excludes any recognized potent medicine from the indigent which is available for the rest of the population.

MISCELLANEOUS

Determined to widely disseminate their stand that it is inappropriate for hospital medical departments to be chaired by persons other than licensed physicians or dentists in acute care general hospitals. Opposed any increase in medical school tuition legislated and instituted for any other reason than inflation. This was to combat some efforts to raise tuition to support a post-graduate medical service system.

Permitted dues-free first year memberships for medical students and encouraged component societies to provide the same.

Took several actions to encourage component societies to streamline membership systems.

Resolved to continue efforts to attract resident physicians to membership, to inform them more fully and encourage their section to establish a liaison with the Council.

Resolved to establish a medical student liaison to the MSMS Council.

Commended MSMS and AMA in their efforts to resist terminology changes in the proposed new JCAH manual which would see "medical staff" become "organized staff"; urged the AMA to continue its efforts in this area, and to allocate financial resources to this effort.

Supported a requirement for a qualified medical director in every skilled nursing home facility, encouraged physicians to continue to care for and serve as advocates of their patients in long-term care facilities.

CONSTITUTION AND BYLAWS

Provided for one Councilor for every 500 members, while discouraging any more Council growth. Declined to add specialty societies caucus representative to the Council.

ELECTIONS/Continued

Re-elected AMA delegates are Thomas R. Berglund, MD, Portage; Robert D. Burton, MD, Grand Rapids; Doctor Crandall, and Donald N. Sweeny, Jr., MD, Detroit. Alternate delegates elevated to delegate positions are Carl Gagliardi, MD, Dearborn; Billy Ben Baumann, MD, Pontiac; Richard Gascoigne, MD, Adrian, and Jay Harness, MD, Ann Arbor.

Named alternate delegates to the AMA are incumbents Doctor Mandell and Robert E. Paxton, MD, Fremont. New alternate delegates are Thomas C. Payne, MD, Lansing; Doctor Tisdel; Richard L. Rapport, MD, Flint; Busharat Ahmad, MD, Marquette; Robert W. Black, MD, Detroit; R. Jack Chase, MD, Grand Rapids, Rhoda M. Powsner, MD, Ann Arbor, and Michael Brennan, MD, resident.

MSMS Secretary Robert M. Leitch, MD, Battle Creek, and Treasurer Leland E. Holly, II, MD, Muskegon were re-elected. Likewise, MSMS Council Chairman Thomas R. Berglund, MD, Portage, and Council Vice Chairman Carl A. Gagliardi, MD, Dearborn, also were re-elected by the Council.

Omnibus medical malpractice bill introduced by Sen. McCollough

Sen. Patrick H. McCollough (D-Dearborn) May 2 kicked off his sponsorship of a five-part omnibus medical malpractice bill. Sen. McCollough and his 33 cosponsors in the Senate (five of them attorneys) believe the new legislation will help hold down health care costs and alleviate another malpractice insurance crisis.

Flanking Sen. McCollough at his Capitol news conference announcing the introduction of the bill were MSMS President Donald K. Crandall, MD, Muskegon, and Michigan Association of Osteopathic Physicians and Surgeons President William G. Anderson, DO, Detroit. Also at the head table were representatives of Blue Cross Blue Shield of Michigan, the Michigan Chamber of Commerce and the Michigan Hospital Association.

"With this bill I am going to take the first concrete step to bringing the skyrocketing costs of medical care under control," announced Sen. McCollough as he opened the news conference. He acknowledged he hopes introduction of this bill will put some pressure on the medical and legal professions. He looks to the two to reconcile over sizes of settlements, lump sum vs. periodic settlement payments, and degree of fault for which a defendant may be held liable in cases involving multiple defendants. "We need to put a lid on health care costs--it was the only industry last year with double digit inflation," he said.

Doctor Crandall explained that MSMS, in supporting this bill, would like to solve the current problems before they affect health care. The severe malpractice insurance availability crisis of the mid-70s could occur again, he said, because companies cannot afford to underwrite the numbers and sizes of claims being awarded.

The new legislation is to improve upon the medical malpractice laws passed in 1975. After introduction on the Senate floor, it was assigned to Judiciary committee.

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Vol. 82, No. 23 May 12, 1983
Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

MSMS ACTIVE ON LEGISLATIVE FRONTS

MSMS President Donald F. Crandall, MD, will testify May 16 in Lansing before the House Special Ad Hoc Committee on Health Care Cost Containment. The committee, led by House Speaker Pro Tem Matthew McNeely, is charged with finding what caused an 11 percent increase in health care costs last year when the 1982 inflation rate was just 3.9 percent. Doctor Crandall will describe MSMS views on health care costs and has been invited to offer recommendations to the ad hoc committee. With high health care costs a hot item currently, there also is a subcommittee on health care costs of the House Public Health Committee, and the Senate is expected to appoint its counterpart to the ad hoc committee.

The five-point omnibus medical malpractice bill supported by MSMS has been assigned a number--SB 224--and is in the Senate Judiciary Committee for initial work. Strongly supported by MSMS, the bill is an amendment to the Revised Judicature Act. It seeks to alleviate the problems of escalating numbers of suits and sizes of settlements before another insurance crisis occurs in Michigan. The bill was introduced by Sen. Patrick McCollough (D-Ypsilanti) and is cosponsored by 33 senators. Many MSMS members contacted their senators urging their cosponsorship of the omnibus bill.

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MSMS members should be watching the Medicaid, public health and mental health appropriations action as the 1983-84 budgetary process rolls along. Early June is the time set for completing the budget. MSMS experts predict continuation of current fund levels, with allowances only for inflation (no new programs).

MSMS BEGINS WORK TO END CHILD ABUSE

Closer cooperation between the MSMS Committee on Child Abuse and Neglect and the state Office of Children and Youth Services is the goal of the two groups following an April 20 meeting. Committee members met at Michigan Department of Social Services offices with Shirley Tate, director of the state office. She provided them with insights into the 1984 state budget regarding child abuse, and said there are no new positions projected for protective services workers. Brooker L. Masters, MD, Baldwin, is chairman of the MSMS committee.

MSMS 'HOUSECALL' DEBUTS MAY 8

Fifty-six mid-Michigan citizens telephoned Channel 47 in Lansing May 8 to ask questions of the physician panel debuting the call-in medical information program, "Housecall." The program, developed by MSMS and hosted by Mert Scholten, MSMS chief of communications, will air at 5:30 p.m. every other Sunday evening. Among mid-Michigan cities in which the program is seen via educational cable stations are Battle Creek, Hastings, Jackson, Alma, Owosso and Howell. Other communities with MSMS-supported call-in MD panel shows are Marquette, Midland and Mt. Pleasant.

COUNCIL HIGHLIGHTS

On April 29 and May 1 in Dearborn, the MSMS Council:

1) Approved a 1983-84 plan of work which sets the following priorities for allocating resources: professional liability, licensing and discipline, new health care delivery models, peer review, practice management, competition, and liaison with specialty societies and non-medical groups.
2) Adopted as MSMS policy a white paper on alternative health care professionals.
3) Approved the backgrounder, "Professional Liability Insurance as a Requisite for Medical Staff Membership," as a reference for MSMS actions. The report will be printed in the June issue of Michigan Medicine.
4) Opposed SB 62, which would impose taxes on services, including physicians'; opposed SB 152, which would make it a felony for any person to cause the death of a viable fetus during the commission of a crime; opposed HB 4090, to establish a cancer registry in the Department of Public Health, and took no further action on HB 4115, which would require all restaurants to display choking first aid posters. The Council supported HB 4177, which would amend the child protection act to define a person responsible for a child's health or welfare and would add emergency medical service personnel, psychologists and family therapists to those who must report suspected child abuse.

CAPSULES

REMINDER: MSMS members may register yet with MSMS or at the door for the May 18 and 19 MSMS TEFRA conferences in Southfield and Lansing, respectively. They are scheduled at the Sheraton-Southfield and Long's Convention Center, Lansing. The registration fee is $25. . . . The MSMS response to the Governor's Task Force on Physician Reimbursement is available to interested MSMS members in booklet form. Contact Dennis Paradis at MSMS headquarters . . . . The omnibus medical liability bill was the subject of the Macomb County Medical Society's first legislative breakfast May 9 in Mt. Clemens. Two co-sponsors of the bill, Sens. Gilbert DiNello (D-Detroit) and David Serotkin (D-Mt. Clemens), attended the breakfast, along with Reps. Nick Chiaramitaro (D-Roseville), Kenneth DeBeaussaert (D-Washington), David Evans (D-Mt. Clemens) and Mary Ellen Parrott (D-Utica). The breakfast was arranged by MCMS Legislative Chairman Ricardo Chalela, MD, Mt. Clemens.

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MICHIGAN MEDICINE

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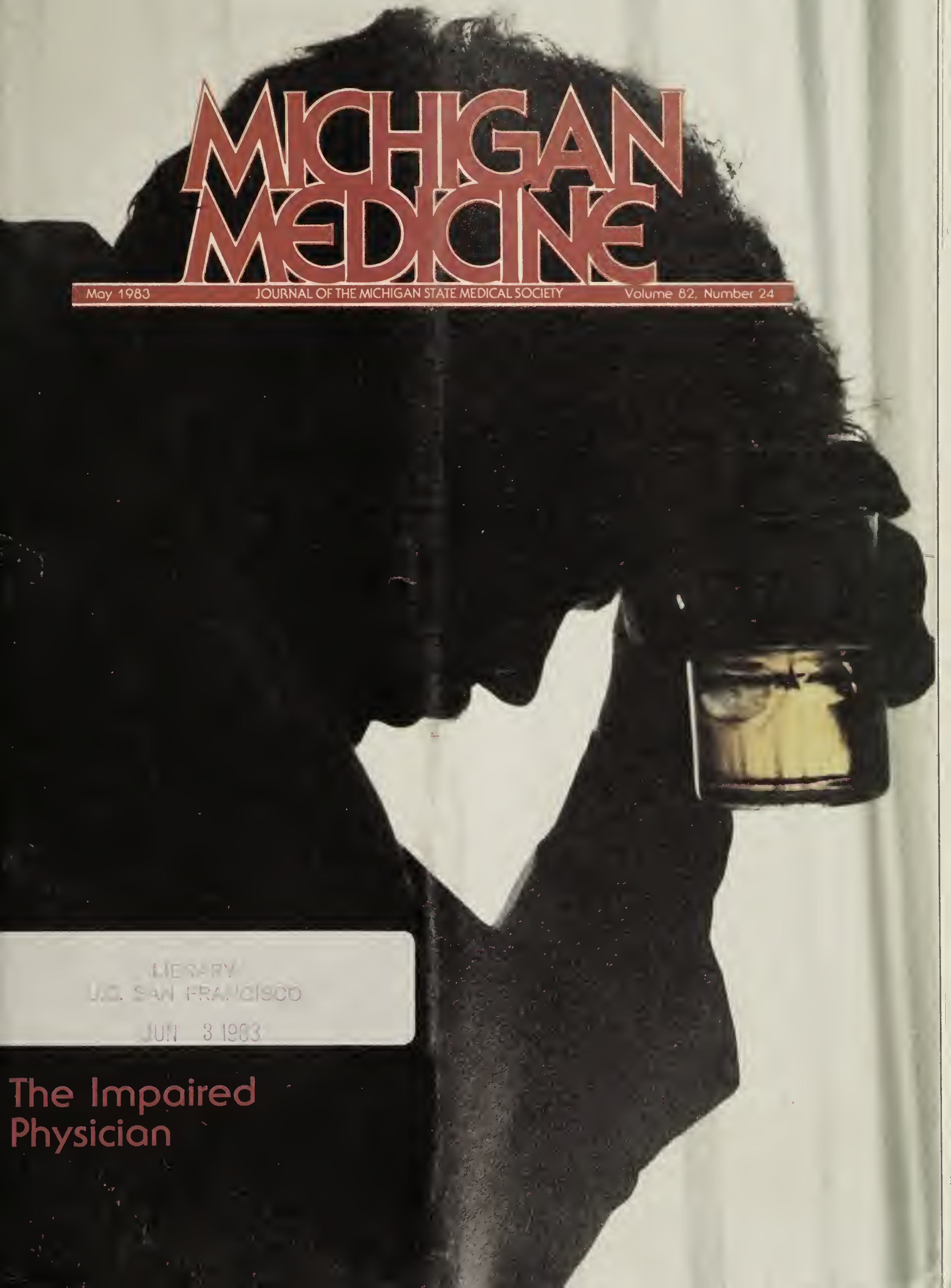

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The Impaired Physician

Brief Prescribing Information

CONTRAINDICATIONS: Patients with severe hypertension, severe coronary artery disease, and in patients on MAO inhibitor therapy, narrow-angle glaucoma, urinary retention, peptic ulcer, during an asthmatic attack.

Hypersensitivity: Contraindicated in patients with hypersensitivity or idiosyncrasy to sympathomimetic amines or phenanthrene derivatives.

Nursing Mothers: Contraindicated because of the higher than usual risk tor infants from sympathomimetic amines.

WARNINGS: Use judiciously and sparingly in patients with hypertension, diabetes mellitus, ischemic heart disease, increased intraocular pressure, hyperthyroidism, or prostatic hypertrophy May produce CNS stimulation and convulsions or cardiovascular collapse with accompanying hypotension.

Use with caution in patients with increased intraocular pressure, cardiovascular disease, hypertension or in patients with a history of bronchial asthma. Do not exceed recommended dose.

Use in Elderly: The elderly (60 years and older) are more likely to have adverse reactions to sympathomimetics. Overdosage in this age group may cause hallucinations, convulsions, CNS depression and death.

PRECAUTIONS: *General:* Should be used with caution in patients with diabetes, hypertension, cardiovascular disease and hyperreactivity to ephedrine. The antihistaminic may cause drowsiness and ambulatory patients who operate machinery or motor vehicles should be cautioned accordingly.

Information for Patients: Antihistamines may impair mental and physical abilities required for the performance of potentially hazardous tasks, such as driving a vehicle or operating machinery, and mental alertness in children.

Drug Interactions: MAD inhibitors and beta adrenergic blockers increase the effect of sympathomimetics. Sympathomimetics may reduce the antihypertensive effects of methyldopa, mecamylamine, reserpine and veratrum alkaloids. Concomitant use of antihistamines with alcohol, tricyclic antidepressants, barbiturates and other CNS depressants may have an additive effect.

Pregnancy Category C: Animal reproduction studies have not been conducted with NDVAFED A capsules. It is also not known whether NDVAFED A capsules can cause fetal harm when administered to a pregnant woman or can affect reproduction capacity NOVAFED A capsules may be given to a pregnant woman only if clearly needed.

Nursing Mothers: Pseudoephedrine is contraindicated in nursing mothers because of the higher than usual risk for infants from sympathomimetic amines.

ADVERSE REACTIONS: Hyperreactive individuals may display ephedrine-like reactions such as tachycardia, palpitations, headache, dizziness, or nausea. Patients sensitive to antihistamines may experience mild sedation. Sympathomimetic drugs have been associated with certain untoward reactions including fear, anxiety, tenseness, restlessness, tremor, weakness, pallor, respiratory difficulty, dysuria, insomnia, hallucinations, convulsions, CNS depression, arrhythmias, and cardiovascular collapse with hypotension.

Possible side effects of antihistamines are drowsiness, restlessness, dizziness, weakness, dry mouth, anorexia, nausea, headache, nervousness, blurring of vision, heartburn, dysuria and very rarely dermatitis. Patient idiosyncrasy to adrenergic agents may be manifested by insomnia, dizziness, weakness, tremor or arrhythmias.

OVERDOSAGE: Acute overdosage with NDVAFED A capsules may produce clinical signs of CNS stimulation and variable cardiovascular effects. Pressor amines should be used with great caution in the presence of pseudoephedrine. Patients with signs of stimulation should be treated conservatively.

DOSAGE AND ADMINISTRATION: One capsule every 12 hours. Do not give to children under 12 years of age.

CAUTION: Federal law prohibits dispensing without prescription.

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and for congestion *without* allergy symptoms **Novafed®**
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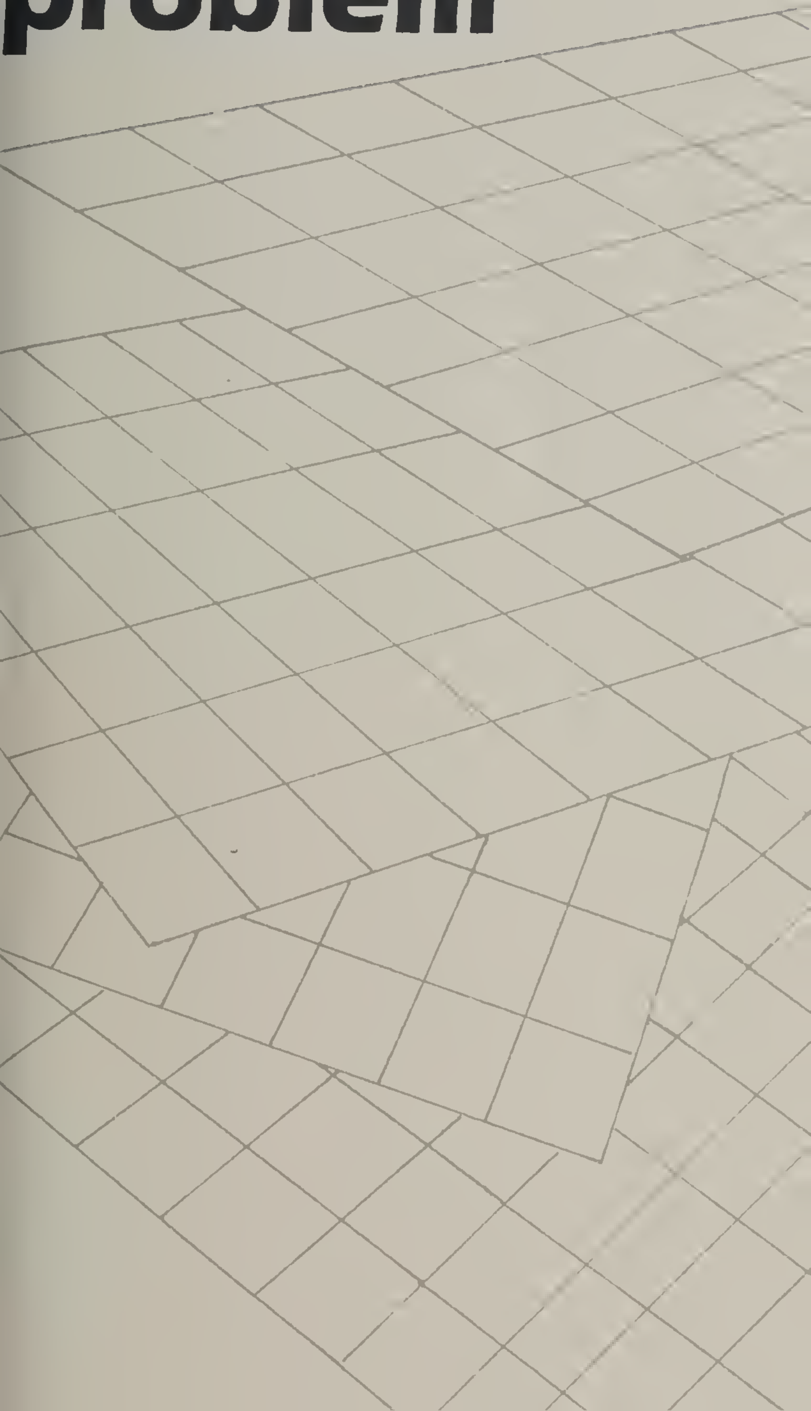
If You and your doctor have a problem



Physician-Patient Relations

High quality medical care depends on a sound patient-physician relationship supported by mutual trust and respect on the part of both patients and their physicians. Since effective medical care often requires the patient to trust his or her physician sufficiently to confide highly personal information necessary for diagnosis, and to follow the treatment prescribed, ethical standards have been developed to foster this special relationship.

Physicians today have inherited a centuries-old tradition of dedicated service to mankind. Nearly 10,000 physicians and medical students have agreed as a condition of their voluntary membership in the Michigan State Medical Society (MSMS) to uphold the highest standards of medical conduct. All MSMS members pledge adherence to the Principles of Medical Ethics, which have their roots in the Oath of Hippocrates dating from the fifth century B.C. Physician members of MSMS (unless engaged in academic teaching, research or administration) must first be licensed to practice by the Michigan Board of Medicine. This is the state agency responsible for administering the laws regulating medical practice in Michigan. You can determine whether a particular doctor is a member of MSMS by asking him or her directly, by contacting the local county medical society, or by contacting the Michigan State Medical Society.

Ethical Concerns

If you have a complaint about a physician, first talk to him or her openly and frankly. A great majority of complaints are simply the result of misunderstanding or faulty communication between the patient and physician, or his or her office staff. If you and your physician are unable to reach an agreement, there are alternatives open to you.

PRINCIPLES OF MEDICAL ETHICS

American Medical Association

PREAMBLE

The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient. As a member of this profession, a physician must recognize responsibility not only to patients, but also to society, to other health professionals, and to self. The following Principles adopted by the American Medical Association are not laws, but standards of conduct which define the essentials of honorable behavior for the physician.

I. A physician shall be dedicated to providing competent medical service with compassion and respect for human dignity.

II. A physician shall deal honestly with patients and colleagues, and strive to expose those physicians deficient in character or competence, or who engage in fraud or deception.

III. A physician shall respect the law and also recognize a responsibility to seek changes in those requirements which are contrary to the best interests of the patient.

IV. A physician shall respect the rights of patients, of colleagues, and of other health professionals, and shall safeguard patient confidences within the constraints of the law.

V. A physician shall continue to study, apply and advance scientific knowledge, make relevant information available to patients, colleagues and the public, obtain consultation, and use the talents of other health professionals when indicated.

VI. A physician shall, in the provision of appropriate patient care except in emergencies, be free to choose whom to serve, with whom to associate, and the environment in which to provide medical services.

VII. A physician shall recognize a responsibility to participate in activities contributing to an improved community.

JUDICIAL COMMISSION
MICHIGAN STATE MEDICAL SOCIETY
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MICHIGAN MEDICINE
The Impaired Physician

Alcoholism is the most common problem of the "impaired" physician. This month's cover highlights that problem, which MSMS is making strenuous efforts to ameliorate; **cover photo by Mert Scholten.**

MICHIGAN MEDICINE

May 1983 Volume 82, Number 24

Special report

278 The goal is to rehabilitate every "impaired" physician plagued with problems of alcohol and/or drug abuse, disrupting mental or physical illness. Articles in this issue describe the work of the MSMS Program to Assist Impaired Physicians. At the invitation of that program's physician leaders, they describe various aspects of the problems. There are articles here on the elderly impaired physician, the medical student in initial stages of impairment, the predisposition of physicians to self-abusive life patterns, physicians and suicide, and the upbeat alternative of healthy living styles; Carl A. Gagliardi, MD; Thomas E. Bittker, MD; Steven C. Scheiber, MD, Rogers Smith, MD, Douglas A. Sargent, MD, Stephen C. Mason, MD, and Joseph Arends, MD.

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To get more copies . . .

of the MSMS Judicial Commission brochure bound here in this magazine, please fill out the form below. The brochures are to be placed in your reception area to help your patients understand the procedures should they have problems with their physician.

Yes, I would like extra copies of the brochure. Please send me: ________ copies. (Single copy free, 50 copies $5, multiples of 100 for $8 each). My check is enclosed, payable to MSMS, P.O. Box 950, East Lansing, 48823 (Attn: Vada Davis)

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Michigan Medicine, the official journal of the Michigan State Society, is dedicated to provide useful information for Michigan physicians about actions of the Michigan State Medical Society and contemporary issues, with special emphasis on socio-economics, legislation and news about medicine in Michigan.

The Michigan State Medical Society Committee on Publications is the editorial board of *Michigan Medicine* and advises the editors in the conduct and policy of the magazine, subject to the policies of the MSMS Council.

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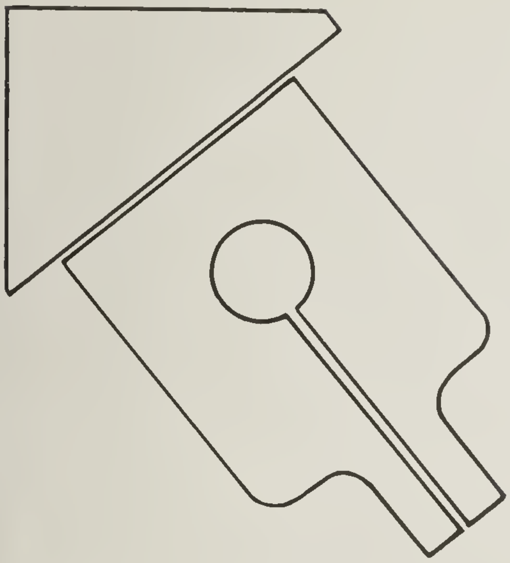
LETTERS



Do doctors care?

During 1982 we filled 22,441 prescriptions valued at $335,036.17 for the needy elderly in the tri-county area.

We must have help to continue this program. These medications are keeping patients out of the hospital. Several weeks ago an elderly lady was going to commit suicide because she couldn't afford food, utilities, medication and her doctor. An agency turned to us for help for her; she is now on our free prescription program. Cases like this cause us to feel morally obligated to keep this program going.

We are asking you to make a special appeal in *Michigan Medicine* for drug samples, microscopes and instruments. Many young American doctors are giving a year and more to the missions and need instruments and microscopes.

With many physicians not doing surgery or laboratory work in their offices now, we are sure there must be many instruments and microscopes available. Our volunteer laboratory technicians are in need of microscopes to complete basic laboratories with requests waiting.

You know, after the work you did on that beautiful article (August, 1982 *Michigan Medicine*), which we really felt would bring in a large response, we are sorry to tell you that there has been almost no response whatsoever. Evidently doctors don't read their magazines or (worse yet) are not concerned about the needs of their needy aged patients or missionaries.

Irene M. Auberlin

P.S. If it would be possible, I would be willing to make a personal appeal at any medical society meeting for medications for these doctors' elderly patients, many of whom, we learn, are being hospitalized for malnutrition because they cannot afford food or prescriptions.

Congratulations

Congratulations to all of you at *Michigan Medicine* for the special award received in this year's Sandoz medical journal competition!

Our records indicate that there is in effect an exchange agreement with the Michigan State Medical Society, yet recently we have not been receiving copies of your publication on a monthly basis. Will you please check into this, and if for some reason, the agreement has lapsed, will you take the necessary steps to reinstate an exchange policy? Thank you for your attention to this request.

Geraldine R. Hutner
Managing Editor
Journal of the Medical Society of New Jersey

World Medical Relief sends $7 million of supplies to Poland

The following update was sent by Mrs. Auberlin recently to Norma Henderson, Farmington, wife of H. Richard Henderson, MD, and a WMR volunteer for almost 13 years:

WMR has assisted 84 relief agencies throughout Michigan, including those funded by United Way who have had their funds drastically cut. From December 1981 through 1982 we have given them 105,228 lbs. of medical equipment and supplies valued at $431,945.21.

We continue to provide free prescriptions to the needy elderly in the tri-county area. Last year we filled 22,441 prescriptions valued at $335,036.17.

All this is in addition to our overseas program which has requests that we can barely keep up with. Eleven shipments have been sent to Poland since May, 1982, under the auspices of the Polish American Congress, weighing 238,788 lbs. valued at $6,704,546.06. A 50-bed hospital was shipped to Haiti in December, weighing 54,839 lbs. valued at $1,130,762.50.

I pray we may always be blessed with friends such as yourself who understand the plight of the poor and do something tangible for the less fortunate.

THE EXPERTS AGREE…

ZYLOPRIM® (allopurinol) IS SIMPLE, EFFECTIVE GOUT THERAPY

Unlike uricosuric agents, Zyloprim® (allopurinol) is clearly the choice for:

OVERPRODUCERS/ UNDEREXCRETERS

"One recent suggestion is that overproducers of uric acid are more 'appropriately' treated with allopurinol and underexcreters with uricosuric drugs. Such an argument is superficially attractive but may be specious: most patients with gout… may nevertheless be managed perfectly well with allopurinol."[1]

–*G. Boss, MD et al*

TOPHI, CALCULI, RENAL DISEASE

"…(1) patients with extensive tophaceous disease…; (2) patients with a history of renal calculi… since a uricosuric drug may exacerbate renal stone disease; and (3) patients with significant renal disease… who are unlikely to respond to a uricosuric drug."[2]

–*Edward W. Hoimes, Jr, MD*

For information on adverse reactions, warnings, etc, please see brief summary of prescribing information below.

ZYLOPRIM® (allopurinol)
100 and 300 mg Scored Tablets

INDICATIONS AND USE: This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim® (allopurinol) is intended for:
1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION.

In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease.

Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Occasional cases of hypersensitivity have been reported in patients with renal compromise receiving thiazides and Zyloprim concurrently. For this reason, in this clinical setting, such combination should be administered with caution.

In patients receiving Purinethol® (mercaptopurine) or Imuran® (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age:

Zyloprim should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or subnormal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully

The most important therapeutic measure is e administration of a drug which will block rate synthesis. The agent available at present is llopurinol (Zyloprim . . .) which is very effective nd of low toxicity."[3]

—Alfred Jay Bollet, MD

. . . allopurinol treatment appears to retard the rogression of renal dysfunction."[4]

—T. Gibson, MD et al

LOW INCIDENCE OF TOXICITY

Clinical experience with allopurinol suggests hat most patients tolerate this drug well—a inding strongly supported by our data. ndesired or unintended effects of therapy ere reported in only 1.8% of 1835 consecutive ecipients."[5]

—G. T. McInnes, MD

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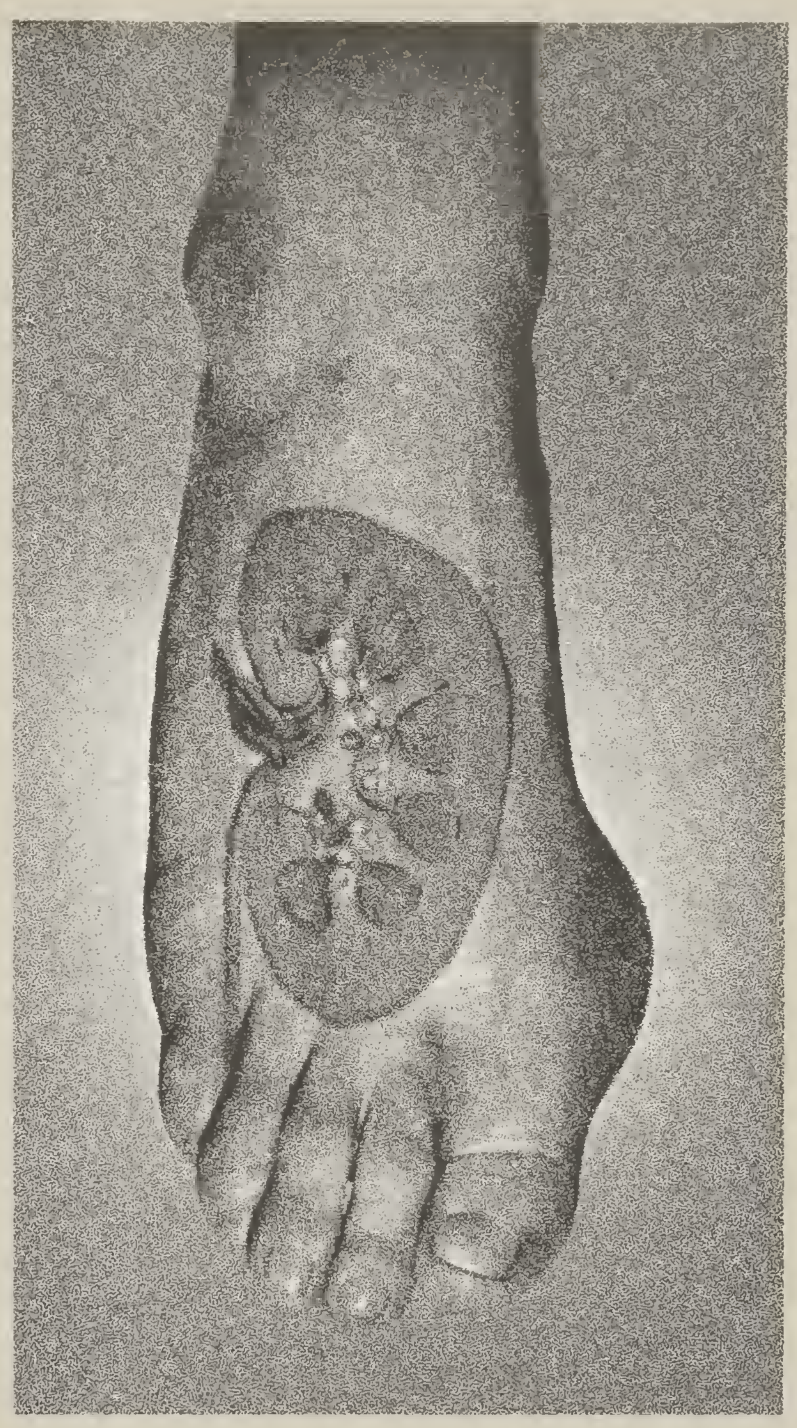

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bserved during the early stages of Zyloprim administration and the drug withdrawn increased abnormalities in renal function appear.

n patients with severely impaired renal function, or decreased urate clearance, the alf-life or oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg er day or 300 mg twice a week, or perhaps less, may be sufficient to maintain dequate xanthine oxidase inhibition to reduce serum urate levels. Such patients hould be treated with the lowest effective dose, in order to minimize side effects.

ild reticulocytosis has appeared in some patients.

eriodic determination of liver and kidney function and complete blood counts should e performed especially during the first few months of therapy.

DVERSE REACTIONS:
ermatologic: Because in some instances skin rash has been followed by severe ypersensitivity reactions, it is recommended that therapy be discontinued at the irst sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually aculopapular, is the adverse reaction most commonly reported. The incidence of kin rash may be increased in the presence of renal disorders.

xfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema ultiforme) and toxic epidermal necrolysis have also been reported.

few cases of alopecia with and without accompanying dermatitis have been eported.

n some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses as been accomplished without untoward incident.

astrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have een reported.

epatic: Rare cases of granulomatous hepatitis and hepatic necrosis have been reported.

ascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angiitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim has been neither implicated nor excluded as a cause of these reactions.

Renal: Rare cases of renal failure have been reported in hypertensive patients who received thiazides and Zyloprim concurrently. Some patients had evidence of hypersensitivity to allopurinol.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, hy Zyloprim has not been reported.

HOW SUPPLIED: 100 mg (white) scored tablets, bottles of 100 and 1000; 300 mg (peach) scored tablets, bottles of 30, 100 and 500. Unit dose packs for each strength also available.

Complete information available from your local B. W. Co. Representative or from Professional Services Department PML.

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SPECIAL REPORT

MSMS goal: to rehabilitate every impaired physician

By Carl A. Gagliardi, MD
Dearborn

> *"Our colleagues shall be our brothers."*

For many years the Michigan State Medical Society sought a method to aid physicians who need help because of drug and alcohol abuse, mental and emotional problems.

As physicians have known how to reach out with a non-judgmental attitude toward their patients, surely they could do as much for their colleagues.

There always have been physicians who exhibit the special characteristics of openness, compassion, and acceptance with a willingness to give of themselves.

It was natural, then, that MSMS establish a formal program. In 1980, the Steering Committee for the MSMS program to assist the impaired physician was formed, and the president of MSMS was named as its chairman. The fact that the society chose its president to head this Steering Committee indicated the importance it placed on the program.

Our society was determined to make available the resources essential for such a program to succeed, namely:

1. Intervention
2. Limited financial assistance
3. Training and intervention skills
4. Educational material on alcohol and drug dependency
5. Listing of treatment centers in Michigan and out of state
6. Confidentiality and responsiveness to the needs of the impaired physicians.

With the state program in place, MSMS next worked to establish the arms of the program, so essential for its success. The county society was a logical locus for committee action, and it offered several specific advantages.

For example, strict confidentiality is easier to achieve within the medical society than in the hospital, which naturally is subjected to the constraints and concerns of the hospital administration. Also, the noncoercive approach, so important to case finding, could easily be compromised in the hospital setting. This again was because of possible administrative requirements to take away staff privileges of the impaired physician.

Still, we hoped that hospitals and specialty societies would form their own committees and that a close and effective liaison between all levels would follow.

Finally, MSMS leaders hoped that local committees would not be labelled "impaired physicians' committees." The objective is to reach every colleague in need and, we hope, to reach them at the earliest possible moment.

The purpose of local committee activity is:

1. To promote heightened awareness of the importance of health and well-being among our fellow physicians.
2. To reach out to troubled colleagues.
3. To facilitate early identification and evaluation of problems and to aid colleagues in finding help.
4. To provide services in a confidential, helpful, compassionate, noncoercive manner that is strictly divorced from any disciplinary aspect of medical practice.
5. To maintain continuing contact with the physician throughout treatment.
6. To assist the recovering physician to reenter practice or to find appropriate alternative employment.
7. To assist the physician in financial need.

There is much work to be done. We must widely involve the medical community if we are to reach our goal of rehabilitating each physician who comes to our attention as impaired.

We must never lose sight of the Hypocratic Oath which states: "I will maintain by all means in my power, the honor and the noble traditions of the medical profession. My colleagues will be my brothers."

Doctor Gagliardi is chairman, Steering Committee on MSMS Committee to Assist Impaired Physicians. He also is vice chairman of the MSMS Council and past president of the Wayne County Medical Society.

Physician disaffection and depression

**By Thomas E. Bittker, MD
Phoenix, AZ**

Physicians are inordinately vulnerable to depression.

They are twice as prone to suicide as are other professional and technical workers. Physicians, at retirement age, are 12 times more prone to suicide than they are at age 35 to 54. The comparable figure on suicide for the general population shows an increase at retirement age of only three times.

Women physicians commit suicide at a rate four times greater than do their age-matched controls. Of 111 women physicians interviewed by Welner and his colleagues, 51 percent had a primary affective disorder compared with the 32 percent prevalence rate found among 103 women PhDs. The rate of depression among the general female population ranges from three to 25 percent. One classic longitudinal study indicates that a propensity for depression and suicide antedates entry into the profession of medicine. Indeed, some have speculated that physicians have a genetic propensity for depression; the same factors that contribute to the compulsive character style, associated with success in medicine, also may predispose toward depression.

MDs' vulnerabilities

Vaillant identifies four virtues prized by physicians which render them vulnerable to depression:

1. altruism
2. independence
3. belief in one's own judgment
4. emotional self-control

Altruism, in the extreme, becomes a denial of one's own needs. Thus, rather than ask for help, the one who feels bad asks, "What can I do for someone else?" Under stress, the altruist simply learns to care for others more assiduously. The selfless physician suffers stoicly, is rewarded for such behavior, and learns to hide the need for help.

Mastering one's own needs for dependence is heavily rewarded by patients and colleagues, who find reassurance in a physician's strength and capacity to give.

Belief in one's own judgment further complicates the problem, particularly for the physician prone to self medicating. Emotional self-control, under stress, becomes detachment from one's own feelings.

Thus, the characteristics contributing to physician success also predispose towards depression. My clinical practice indicates that physicians typically experience a phase of disaffection from medicine prior to suffering clinical depression. These physicians have a history of over-

Continued on page 293

How to cope

How can physicians cope with the challenges and stresses that their professional roles place on them? I offer below several suggestions that have worked in my clinical practice:

First, become aware of one's strengths and liabilities as a person. Review with trusted friends and family the specifics of how one's being a physician affects each person. By sharing an understanding of the problem associated with the physicianhood, one mitigates against unnecessary resentment and guilt.

Second, become a student in learning how to live. Appreciate that we resemble the dinosaurs, overly specialized in one area of development — the intellectual and technological — but quite undeveloped in other areas — the interpersonal.

This is a byproduct of our very competitive, technically oriented educational system. We are, however, good students and should employ our learning skills in behalf of developing skills in intimacy and at play. Set aside time for cultivating other aspects of life beyond medicine.

Third, schedule high-priority time for family activities and for recreation. Be firm in arranging on-call responsibilities so that they do not intrude on essential recreational functions.

Fourth, develop a personal long-range plan with your spouse. Explore ways to include in your daily existence activities that have relevance to your long-range plans. Such plans should not be merely dreams but rather programs for living.

Critical in all of the above is time for being, time for pleasure, and opportunities for good humor. The first step in learning about ourselves should be taken with humility.

(References are available from the author.)

Articles on this and following pages were solicited by the MSMS Program to Assist Impaired Physicians. They are written by leading national experts.

Doctor Bittker is chairman, Physician's Health Committee, Arizona Medical Association, and associate in psychiatry, University of Arizona Medical School, Tucson.

We physicians must care for our medical students

By Stephen C. Scheiber, MD
Tucson

This paper was presented to the AMA Fifth National Conference on the Impaired Physician, Portland, Oregon, September 24, 1982.

Doctor Scheiber is professor in the Department of Psychiatry, Arizona Health Sciences Center.

Introduction

The current medical education system may contribute to medical students' impairment.

One factor is the incredible amount of information that students are asked to learn in a short time. Too often faculty members are geared toward students' extensive learning of content, rather than toward establishing life-long patterns of learning.

Regurgitating facts takes precedence over health and well-being. Some faculty members threaten students that if they fail to learn certain material future patients may die.

Ironically, these threats often are made by basic scientists who have no clinical basis for making them. There is a need for concerted action to change such scare techniques.

Curriculum

The curriculum committees of medical schools too often do not stagger examinations in the basic sciences or curtail extra hours in lecture halls and laboratories. They devote insufficient time in the curriculum to helping students learn to balance personal needs with academic requirements. Clinical faculty and curriculum committees too often ignore students' fatigue from excessive hours on duty on certain clinical clerkships.

Advisory systems

The current system of faculty advisers is, in most institutions, unsatisfactory. The assigned adviser occasionally will meet with the student during basic science years, and perhaps become acquainted when the student is considering house officership. Then the adviser may write a perfunctory letter on behalf of the student to help him or her get a "good" internship. This often is the extent of the relationship.

Some medical schools have experimented with an "older buddy" system, whereby a senior student is assigned to help a freshman through the rigors of the first two years. This is a poor substitute for medical fraternities which were more prevalent in previous decades.

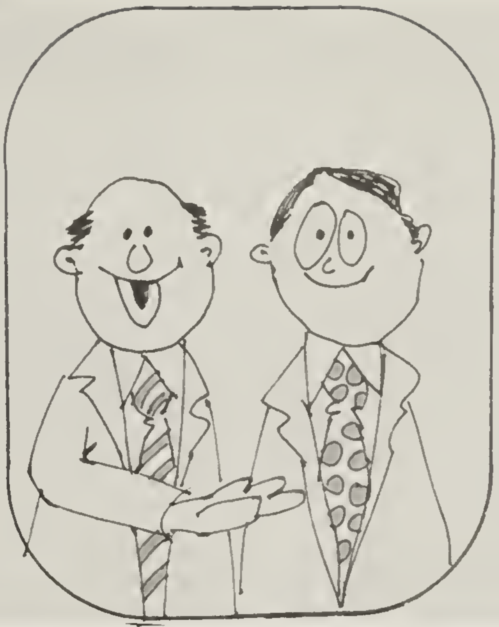
Within medical fraternities, students at lower levels met with senior students and alumni in practice or on faculties, to discuss "survival and beyond survival," a term used by Pat Tokarz in his book on coping for residents.

Admissions

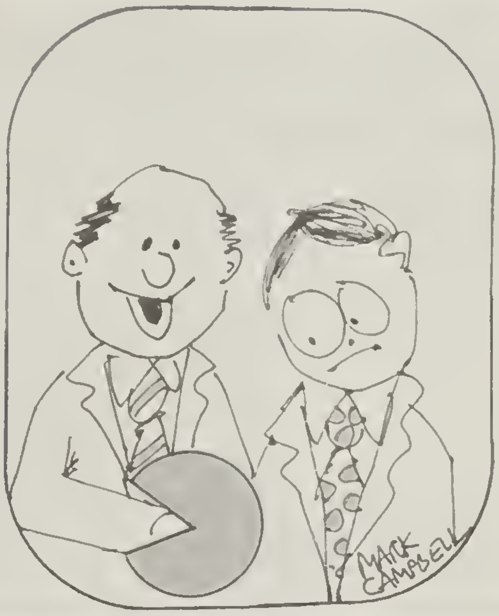
In spite of a very inadequate admissions process in most institutions whereby grade point averages and MCAT scores are valued because of their "hard data," many schools fail to review the histories of students to identify high risk populations. They rarely obtain health histories. The family physician often uses the health report requested for admissions to support the candidacy of his former patient rather than detailing physical and emotional problems of the candidate and the candidate's family. It is well known, for instance, that familial alcoholism is a serious medical problem which is passed on from generation to generation. Likewise, strong family histories of depression and suicide increase the risk for a medical school candidate. Schools frequently don't obtain knowledge of these vulnerabilities and put forth little effort to help vulnerable students through

DOCTOR QUICK-DRAW

Nicotine, food, narcotics and alcohol addiction are very common throughout the world . . .



MSMS is attempting to help with the impaired physician programs . . .



. . . but dealing with those Pac-Man addicts has been the most difficult!

the difficult periods of medical school.

Health care systems

Even the most foolproof system of screening candidates and the identification of vulnerable populations are insufficient. We need to establish a network to enable medical students to seek help in a confidential, nonthreatening atmosphere. Should a student exhibit any signs or symptoms of depression, alcoholism or substance abuse, he or she should have little fear of punitive action.

In a workshop sponsored by the American Medical Student Association, the principal concern of the medical students was that if they sought help there would be automatic feedback from the caring therapist to the Dean's office, and this, in turn, would jeopardize their careers.

Indeed, in some schools, the Department of Psychiatry has combined the faculty-student relationship with the role of faculty psychiatrist and student patient.

In such a dual capacity, the faculty psychiatrist will learn details about the student's life which can lead to questions about the student's capacity to remain in medical school. The Dean's office expects that any faculty member will not allow a student to continue on course in the medical school if the faculty member has reservations about the student's capacity to function.

In an ideal setting, once there are suggestions of impairment, the faculty has to be warm, caring, concerned and responsive. Faculty members must be willing to confront aberrant behavior. Faculty members also have an obligation to aid students to seek care in the health care system and allow the student time to receive the necessary help. Again, ideally, the psychiatric help should be sought in a setting separate from the Department of Psychiatry of the medical school.

As a faculty member at the University of Arizona, I have been appalled over the last 12 years by the attitude of students regarding their own health.

Neglect of health

During a psychiatric clerkship, I once noted a medical student going into the medical director's drawer, taking out sample medications and popping pills during classroom sessions.

I inquired first how the student was feeling. In a fairly typical reaction of denial, the student told me there was nothing wrong. I continued to observe his behavior and then confronted him.

He identified the pills as antacids. When I suggested that he seek medical attention he initially protested its utility. Finally, I insisted the student seek help and he agreed to see a gastroenterologist. A peptic ulcer was diagnosed and he received appropriate treatment. He was grateful for my persistent, if not nagging, behavior.

The neglect of medical student health is a long-standing problem. The executive physical, a regular comprehensive physical examination, is not part of a medical student's personal experience. Though medical students generally are healthy, medical school faculty members pay far too little attention to sustaining students' healthy lifetime patterns, such as periodic physicals. Indeed, they are rarely mentioned to the medical student. Most schools do not require physical examinations after admission to medical school.

The attitudes of medical students and faculty members strongly reflect the prevalent attitude toward psychiatric problems and substance abuse in our larger culture. As with the medical profession at large, a suicide temporarily will rally the medical school community to look at itself and to seek better methods of prevention, early identification, and therapeutic intervention.

However, when the stunning reactions of guilt, anger and helplessness fade, the medical school faculty returns to daily routines, and interest in preventing impairment assumes a low priority. A major challenge is how to establish and maintain a caring attitude toward our medical students through training. We must improve institutional attitudes towards medical student health.

The problem of the elderly impaired physician

By Rogers J. Smith, MD
Portland, Oregon

In a landmark report on "The Sick Physician" in 1972, the AMA Council on Mental Health clearly delineated the major problem of physician impairment. The Council defined it as "the inability to practice medicine adequately by reason of physical or mental illness, including alcoholism or other drug dependence."

In the ensuing decade the interest in this area has expanded geometrically. But we have failed to discover and diagnose psychiatric disorders of physicians in comparison to dealing with alcoholism and other drug dependence within the medical profession.

At the outset, we anticipated a number of barriers to extension of the program. They included the longstanding "conspiracy of silence" which had surrounded these problems in the past, and also involved the high degree of denial on the part of ill physicians that any problem could exist.

Doctor Smith is immediate past chairman of the AMA Council on Scientific Affairs and the "dean" of the AMA's effort to help impaired physicians.

Invisible illness

These obstacles largely have been broken down; but it still is apparent that many psychiatric illnesses in physicians remain undiagnosed and undetected. A major problem is the invisibility of such illnesses except to the closest family members and associates. These physicians are aware of their illness and often have reached an accurate diagnosis, but they are convinced they can work through it without assistance and they avoid treatment.

The AMA adopted the report of the Council on Mental Health policy, with the statement that "It is a physician's ethical responsibility to take cognizance" of a colleague's impairment. From this assertion there has been an unprecedented development of state medical association programs directed to the problem.

At the outset, only seven state associations had a standing committee interested in the matter of physician illness. Currently, every state medical association has such a committee and all are active individually and sometimes in concert with committees in neighboring states.

These committees vary in their approach to the problem, in their relationship with their local licensing authority and in their approach to the affected physician. Some keep no records and will attempt to help only if the physician wants help. Others have an actively assertive approach which clearly identifies the physician's needs for treatment and which threatens to carry the problem to the Board of Medical Examiners if the physician does not cooperate and, particularly, if the impairment is sufficient to threaten harm to patients.

In spite of variations among the state association programs, they share the components of case detection, confrontation or intervention and some sort of inducement to enter treatment. Most of these programs also persist with a continuum of concern, functioning as an advocate of the physician throughout the process of treatment, rehabilitation and practice re-entry.

Varying figures, as hard data still are difficult to come by, indicate that in this decade of activity, some 1,600 impaired physicians have been approached in the United States with nearly 1,300 of these entering treatment. Treatment was successfully completed by 600 physicians.

We do not know how many of these cases represent mental illness rather than drug dependence, including alcoholism. An AMA survey provided some clues, one in the area of program emphasis and the other in the composition of state association committees. Although practically all of the survey respondents indicated their concern with psychiatric illness as well as with substance abuse, none of them mentioned psychiatric illness as the primary emphasis of their body and only 11 gave any indication of physician referral specifically for psychiatric treatment.

On the other hand, 10 of the societies reported explicitly about giving primary emphasis to alcoholism in particular and other drug abuse secondarily. Serving on the medical society committees were a total of 481 physicians. Of these 28 percent were psychiatrists, which is an appreciable proportion. But they were thoroughly outnumbered by a second identifiable group — the 34 percent of committee members who were known to be recovering alcoholics or former drug dependent patients.

Further bias

It was further noted that the leadership of most medical society programs emanated from the latter group. Certainly alcoholism is the most common impairing disorder and the recovery programs always involve active participation by the patients in the treatment of other alcoholics as a part of their own rehabilitation process.

These characteristics of the committee mitigate against the psychiatrically impaired physicians. Certainly if the program's written objectives emphasize alcoholism and drug abuse, these will be the disorders that will come to the attention of the committee. If there is further bias in the structure of the program's leadership, these will be the cases actively detected, confronted and treated.

This unfortunate skew is reinforced by the anti-psychiatry attitude of many individuals in the alcoholism treatment field. We must obviously allow for differences of opinion over whether alcoholism is a psychiatric illness and whether psychiatric treatment is effective with alcoholic patients.

However, many recovering alcoholic participants in impaired physician programs lean toward the negative side and this can constitute an additional reason for conscious (or otherwise) avoidance of contact or involvement with impaired physicians who do not have a substance abuse problem.

Of particular concern is the aging physician who often is faced with adjustment and other emotional problems, if not the inroads of frank organic mental disorder. Several medical associations feel that the most difficult segment of the physician population to deal with is that of the aging physician. They have outlined problems expressed as:

How do you tell a person that he or she needs to slow down and carry less of a load?

How do you convince a department head that he or she is over the hill and should retire?

There is a mythology about the aging process with misconceptions even in the minds of psychiatrists. Old people do not inevitably become senile, unproductive, or bereft of their faculties. Each of us can name a number of individuals in their ninth or tenth decade of life who are alert, clear of mind and active mentally within whatever limitations are imposed by physical problems attendant upon increasing age.

One feature of some elder physicians has to do with their changing style of practice as their longevity grows. Many such individuals are isolated from their colleagues, practicing only in a neighborhood office in the midst of an extremely loyal patient population which has known "our Doctor John" for as much as half a century.

These patients often are quite aware of their guardian's defects, habits and inabilities. "Of course we know that Doctor John has a nip now and then." "Sure, Doctor John's memory isn't as good as it used to be, but he's taken care of me for years, delivered all my kids and I trust him."

Very often these physicians no longer are associated with organized medicine and belong to no hospital staff, thus preventing even casual or informal monitoring of their functional capabilities. Often a problem becomes apparent only with some, however accidental, flagrant error of omission or commission in the framework of practice. How do you react when that problem occurs in the person who brought you into the office, whose kind hand and word have seen you through past crises?

Some boards of medical examiners have approached the problem directly, where competent patient care seems compromised in the practice of elder physicians. The physician is brought in and firmly and kindly given the single option of surrendering his or her license and continuing activities in medicine in some area not involving patient care. Here the role of the medical society becomes critical.

Compatriots fail

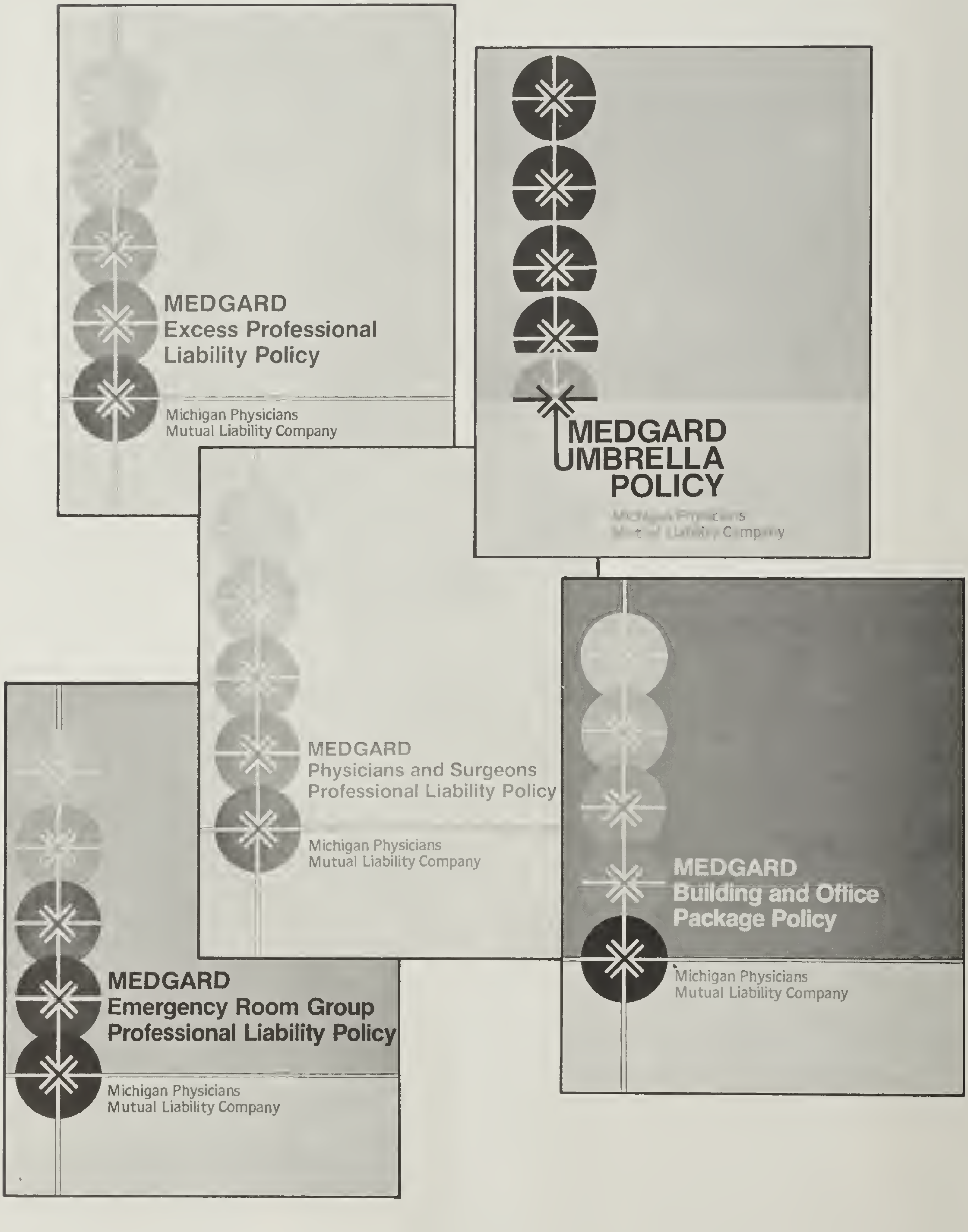
First, it must be willing to embark upon such a program and second, it must actively pursue other options for professional activity. It must either involve the physician only under supervision or in a pursuit where actual patient care and contact is not involved.

In an occasional senior practitiner, a situation of legal portent may arise in the absence of any dementing loss of brain tissue function. As the years go by some of our compatriots fail, for whatever reason, to keep abreast of new technologies — diagnostic and therapeutic. Combined with the prescribing bent that most of us have this dovetails neatly into a further phenomenon. Not only does his practice diminish quantitatively but there is also a qualitative shift in the type of patient that appears in his waiting room. The ages vary but the complaints are limited and similar — of sleep disorders and of bouts of severe pain. These patients seem versed in their complaints and know what Schedule II drug "helped a lot the last time," and they are prompt with their cash payments. Confronting these physicians with their drug diversion may well require assistance from the licensing authority or the Drug Enforcement Administration should medical society intervention fail. There is no place in practice for "script writers" who compromise safe, competent patient care.

Certainly, psychiatrists as well as other medical specialists can assist aging physicians in their process of adaptation to retirement. By so doing we can help prevent psychiatric problems from developing in the future for our brothers — and sisters — and even for ourselves.

More on pages 286, 287, 288, 293, 294

WHAT YOU SEE.



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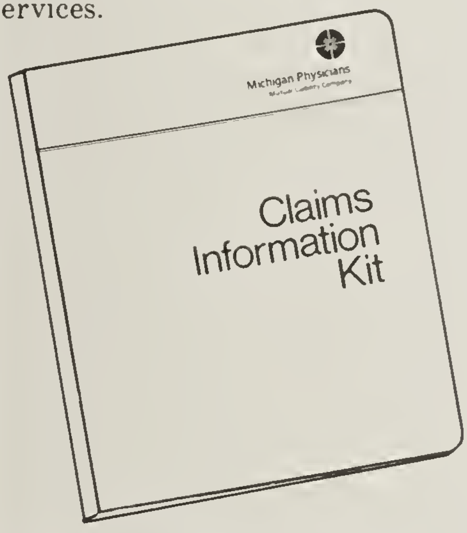

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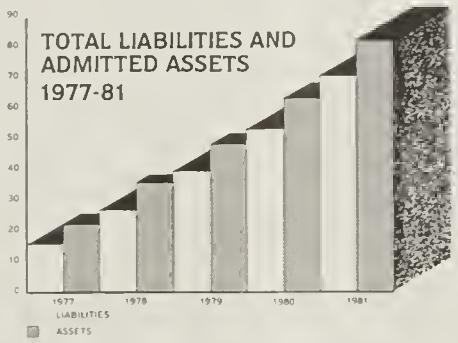

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Suicide most dramatic symptom of physician impairment

By Douglas Sargent, MD
Grosse Pointe Farms

Some doctors kill themselves at the apex of their careers, leaving behind distraught spouses and children, disillusioned patients, puzzled colleagues. They also leave behind many questions.

How is it possible that physicians, experts in health maintenance, can fall victim to supposedly preventable and treatable disorders? And how can this happen, especially when they are surrounded by caring persons who ought to be able to prevent such apparently needless deaths?

To answer this question, the AMA/APA Physician Mortality Project studied confirmed and possible suicides reported to the AMA in 1980 and 1981 from five states: Arizona, California, Oregon, Pennsylvania and Michigan.

After reviewing the report of the pilot study, the AMA House of Delegates approved the major recommendation of the pilot phase: to extend the five-state pilot into a national study.

I would like to tell you about Michigan's role in the pilot phase. I also will sketch the profile of the physician who is vulnerable to suicide, using leads uncovered in the pilot phase, in order to enhance recognition and early intervention. Finally, I will tell you what is planned for the future.

Why study suicide?

Suicide is the most dramatic — and most permanent — symptom of impairment in physicians. Some impaired physicians may die slowly of terminal alcoholism, and others may die accidentally or subside slowly into a vegetative existence from chronic diseases. But suicide remains the least discussed and perhaps most preventable fatal consequence of impairment.

Suicide often removes from our midst a physician in mid-career whose impairment may be recent, reversible and the product of a temporarily disabling disorder that might have been treatable. Almost before colleagues notice anything is seriously wrong the physician is gone. Too late, we wonder how we physicians might better protect our colleagues or ourselves. One way is to study the problem and find solutions.

The Michigan project

The pilot phase of the study in Michigan involved 30 psychiatrists, members of the Michigan Psychiatric Society who volunteered to interview survivors of deceased physicians. Auxilians under the able leadership of Donna Chase, then MSMS Auxiliary president, located interviewees, often a very difficult task, and arranged for the interviews. Joyce Mason, MD, an Ann Arbor psychiatrist who has worked closely with the auxiliary, was liaison with auxilians and interviewers.

I had the pleasure of guiding the effort in Michigan. With the help of Wayne State University's Computer Sciences Center, my assistant, Marcia Mouron, extracted the data from an enormous stack of questionnaires, organized it, and Mary Pietrangelo helped her to transfer it to computer files.

These data, from Michigan and the other states, were the basis for the final report of the pilot phase. From these data, which are still undergoing study, a rough outline of the suicidal physician can be sketched. Few will have difficulty recognizing the profile of an impaired physician.

Suicidal physician profile

He is depressed, overworked, irritable. He worries unrealistically about money. He may be involved in a malpractice suit, a disciplinary action or suspension of his medical license. Unlike the situation with his non-suicidal colleagues, these actions are most likely to be resolved against him.

Although, like half of his colleagues, he is a "workaholic," he does not take the satisfaction from his work that others do. He has trouble with colleagues and may express bitterness toward them or toward medical practice. Some view him as mildly irresponsible toward patients. At the time of death he may be practicing incompetently.

He will have suffered a significant personal or professional loss shortly before his death. He is drinking more than usual. He takes more satisfaction in solitary activities than in family affairs.

To this picture may be added a chronic, debilitating physical disorder. He is likely to have been in psychiatric treatment at some time earlier. The lethality of his mental state may have been underestimated, but often his death at some future time has been anticipated by a resigned family, who have become exhausted from coping with his moods and his increasingly incongruous behavior. Some family members may have become indifferent.

Often the suicidal acts that terminate these unhappy lives are "telegraphed," so that opportunities seem to have existed for prevention. But the data so far do not permit us to offer reliable suggestions about how this may be accomplished. In like fashion, although individual cases seem to link the suicide clearly to what look like

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Doctor Sargent is chairman, AMA Council on Scientific Affairs Panel, Physician Mortality Project, and chairman, Wayne County Medical Society Health and Well-being Committee.

precipitating events, in others the connection is obscure, so that the use of such events as warnings must await the firmer data that the full-sample study should produce. To find such opportunities for prediction and prevention are major goals of the national study.

Lethal lifestyles

In addition to confirmed and "possible" suicides, the pilot project uncovered physicians who lived, and eventually succumbed to, what I call "lethal lifestyles." Included in this group are physicians who took needless risks in hazardous recreational activities, physicians who literally worked themselves to death despite known and life-threatening physical illnesses, and physicians who habitually seemed to be gambling with fate, their lives constantly in the balance.

While the study could not detect how many physicians may gamble with their lives and win, the preliminary data suggest that a substantial number lose. Among the losers are many physicians who enjoyed the respect of colleagues for their outstanding medical achievements, who were loving and devoted husbands and fathers and whose loss to society was very great. While we mourn their passing we also must search for ways to prevent such losses.

The full-sample study

Early in December the AMA House of Delegates approved the final report of the pilot phase and extended the study to all suicides and possible suicides known to the AMA to have occurred in the other 45 states in the years 1980 and 1981. Work already is underway to improve the questionnaire and other methods employed in the pilot study. Psychiatrists and spouses who participated in the pilot study have been asked for their suggestions about how best to conduct the full-sample study.

Surprisingly, although they found the experience emotionally draining, the overwhelming majority of surviving spouses interviewed (37 out of 41 responding to the question) felt that the interview process also was rewarding. As one physician's widow put it, "After my husband died, I felt cut off from our friends in medicine. After a life in medicine, this was a big loss. The interview reconnected me to medicine. For this I am grateful."

The American Psychiatric Association already is extending the study to all psychiatrists known or suspected to have killed themselves during this same time period. We also are seeking a better way to locate survivors and elicit their cooperation.

Are impaired physicians suicidal?

The eventual goal of the Physician Mortality Project is prevention. Impaired physicians are a target group because there is a direct connection between impairment and suicide.

Crawshaw has shown that 25 percent of physicians on probation in Oregon killed themselves within one 18-month period. All of the suicidal physicians whose deaths were studied in the pilot phase were judged to have been impaired to a significant degree when they died. Other studies show that chemically dependent or depressed physicians are at great risk to suicide.

Clearly, suicide prevention services are likely to find

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*Shils ME, Randall HT: Diet and nutrition in the care of the surgical patient, chap. 36, in *Modern Nutrition in Health and Disease*, edited by Goodhart RS, Shils ME; Philadelphia, Lea & Febiger, 1980, p. 1084.
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employment among a population of impaired physicians. The good news is that, if identified and reached in time, impaired physicians respond favorably to treatment. Writing in the December 17, 1982 issue of *JAMA*, James H. Shore, MD, an Oregon psychiatrist, reported his study of 45 physicians on probation. While confirming earlier studies showing that 75 percent of physicians on probation are chemically dependent or mentally ill, Doctor Shore's study also showed that after 42 months on probation, 75 percent of these were judged improved and in active practice. The inescapable conclusion is that finding and treating impaired physicians can save their lives; neglect condemns many of these doctors to death, often at their own hands.

In addition to interviewing survivors of deceased physicians in every state, the full-sample study will intensify the study of cases that yield especially useful information about the presuicidal state, a time when preventive intervention is likely to be most needed and may be most effective. Deaths among physicians with lethal lifestyles will receive the same intensified scrutiny for the same reason. The team of researchers will seine the enlarged pool of data for statistically valid clues that will facilitate earlier detection of vulnerable physicians. The Michigan volunteers who managed the pilot phase will continue to guide the expanded study.

Even before the study is completed some of the pilot phase suggestions will be implemented. The report of the pilot phase, which the AMA adopted, encourages state medical society programs like Michigan's to ". . . become more alert to the psychiatric problems of troubled colleagues and assure early therapeutic intervention. They also should intensify their efforts during the impaired physician's recovery period to break down barriers of stigma and prejudice that too often isolate or hinder the rehabilitated physician who attempts to return to practice."

In addition, auxiliaries are encouraged to provide support to the families of deceased physicians who have experienced the additional trauma of losing "their doctors" to suicide. Finally, medical educators are urged to promote student health, and prevent suicide and other forms of premature death after graduation, too, by emphasizing the mental health value of fulfilling personal and social needs as well as professional ones, both during and after medical school.

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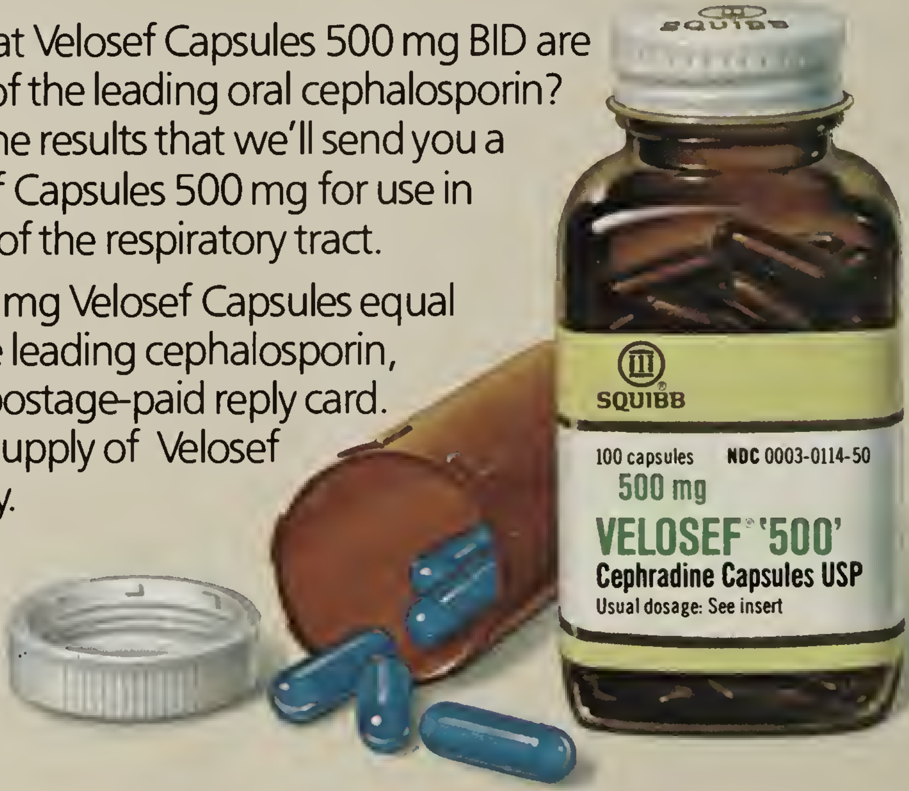

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INDICATIONS AND USAGE: These preparations are indicated for the treatment of infections caused by susceptible strains of designated microorganisms as follows: Respiratory Tract Infections (e.g., tonsillitis, pharyngitis, and lobar pneumonia) due to *S. pneumoniae* (formerly *D. pneumoniae)* and group A beta-hemolytic streptococci [penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever; Velosef (Cephradine, Squibb) is generally effective in the eradication of streptococci from the nasopharynx; substantial data establishing the efficacy of Velosef in the subsequent prevention of rheumatic fever are not available at present]; Otitis Media due to group A beta-hemolytic streptococci, *H. influenzae,* staphylococci, and *S. pneumoniae;* Skin and Skin Structures Infections due to staphylococci and beta-hemolytic streptococci; Urinary Tract Infections, including prostatitis, due to *E. coli, P. mirabilis, Klebsiella* species, and enterococci *(S. faecalis).*

Note: Culture and susceptibility tests should be initiated prior to and during therapy.

CONTRAINDICATIONS: In patients with known hypersensitivity to the cephalosporin group of antibiotics.

WARNINGS: *Use cephalosporin derivatives with great caution in penicillin-sensitive patients since there is clinical and laboratory evidence of partial cross-allergenicity of the two groups of antibiotics; there are instances of reactions to both drug classes (including anaphylaxis after parenteral use).* In persons who have demonstrated some form of allergy, particularly to drugs, use antibiotics, including cephradine, cautiously and only when absolutely necessary.

Pseudomembranous colitis has been reported with the use of cephalosporins (and other broad spectrum antibiotics); therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with antibiotic use. Treatment with broad spectrum antibiotics alters normal flora of the colon and may permit overgrowth of clostridia. Studies indicate a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis. Cholestyramine and colestipol resins have been shown to bind the toxin *in vitro.* Mild cases of colitis may respond to drug discontinuance alone. Manage moderate to severe cases with fluid, electrolyte and protein supplementation as indicated. Oral vancomycin is the treatment of choice for antibiotic-associated pseudomembranous colitis

produced by *C. difficile* when the colitis is severe or is not relieved by drug discontinuance; consider other causes of colitis.

PRECAUTIONS: General: Follow patients carefully to detect any side effects or unusual manifestations of drug idiosyncrasy. If a hypersensitivity reaction occurs, discontinue the drug and treat the patient with the usual agents, e.g., pressor amines, antihistamines, or corticosteroids. Administer cephradine with caution in the presence of markedly impaired renal function. In patients with known or suspected renal impairment, make careful clinical observation and appropriate laboratory studies prior to and during therapy as cephradine accumulates in the serum and tissues. See package insert for information on treatment of patients with impaired renal function. Prescribe cephradine with caution in individuals with a history of gastrointestinal disease, particularly colitis. Prolonged use of antibiotics may promote the overgrowth of nonsusceptible organisms. Take appropriate measures should superinfection occur during therapy. Indicated surgical procedures should be performed in conjunction with antibiotic therapy.

Information for Patients: Caution diabetic patients that false results may occur with urine glucose tests (see PRECAUTIONS, Drug/Laboratory Test Interactions). Advise the patient to comply with the full course of therapy even if he begins to feel better and to take a missed dose as soon as possible. Tell the patient he may take this medication with food or milk since G.I. upset may be a factor in compliance with the dosage regimen. The patient should report current use of any medicines and should be cautioned not to take other medications unless the physician knows and approves of their use (see PRECAUTIONS, Drug Interactions).

Laboratory Tests: In patients with known or suspected renal impairment, it is advisable to monitor renal function.

Drug Interactions: When administered concurrently, the following drugs may interact with cephalosporins:

Other antibacterial agents — Bacteriostats may interfere with the bactericidal action of cephalosporins in acute infection; other agents, e.g., aminoglycosides, colistin, polymyxins, vancomycin, may increase the possibility of nephrotoxicity.

Diuretics (potent "loop diuretics," e.g., furosemide and ethacrynic acid) — Enhanced possibility for renal toxicity.

Probenecid — Increased and prolonged blood levels of cephalosporins, resulting in increased risk of nephrotoxicity.

Drug/Laboratory Test Interactions: After treatment with cephradine, a false-positive reaction for glucose in the urine may occur with Benedict's solution, Fehling's solution, or with Clinitest® tablets, but not with enzyme-based tests such as Clinistix® and Tes-Tape®. False-positive Coombs test results may occur in newborns whose mothers received a cephalosporin prior to delivery. Cephalosporins have been reported to cause false-positive reactions in tests for urinary proteins which use sulfosalicylic acid, false elevations of urinary 17-ketosteroid values, and prolonged prothrombin times.

Carcinogenesis, Mutagenesis: Long-term studies in animals have not been performed to evaluate carcinogenic potential or mutagenesis.

Pregnancy: Teratogenic Effects/Impairment of Fertility — Category B: Reproduction studies have been performed in mice and rats at doses up to 4 times the maximum indicated human dose and have revealed no evidence of impaired fertility or harm to the fetus due to cephradine. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, use this drug during pregnancy only if clearly needed.

Nursing Mothers: Since cephradine is excreted in breast milk during lactation, exercise caution when administering cephradine to a nursing woman.

Pediatric Use: Adequate information is unavailable on the efficacy of b.i.d. regimens in children under nine months of age.

ADVERSE REACTIONS: Untoward reactions are limited essentially to G.I. disturbances and, on occasion, to hypersensitivity phenomena. The latter are more likely to occur in persons who have previously demonstrated hypersensitivity and those with a history of allergy, asthma, hay fever, or urticaria.

(continued on next page)

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(continued)

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How the MSMS Impaired Physician Program works

By Stephen C. Mason, MD
Ann Arbor

The MSMS Program to Assist the Impaired Physician works through its steering committee, consisting of the program chairman plus chairmen of subcommittees on Education and Training, Intervention and Treatment, Promotions, Physician Loan Fund, Research and Development, Medical Student Well-Being, and the Auxiliary Liaison.

New guidelines have decentralized the operation of the program and spelled out its helpful, confidential, non-coercive, and non-punitive nature. A procedures section of the guidelines details the way to proceed.

MSMS has held training workshops two to three times per year to initiate health and well-being committee members into the complexities of helping troubled colleagues and to establish standards of performance. These workshops now are given at both beginning and advanced levels. They also have been useful in giving auxiliary members some exposure to the program and in helping them to see their role on behalf of families of impaired physicians. The Auxiliary is a vital part of the program. It has much to contribute to early case finding and to generating a general acceptance of the program which is so essential to its success.

One subcommittee of the central committee is devoted to carrying out the intervention function of the old central committee, except that its activity is also supervisory and advisory when the local health and well-being committees need help. This is a considerable change from the days when the problem was just ignored. We now have a system which can handle the crises, as well as promote self-

Doctor Mason is a psychiatrist and is a member of the Steering Committee on the MSMS Program to Assist Impaired Physicians.

DEPRESSION/*Continued from page 279*

achievement and entered medicine with the expectancy of finding a profession that would allow intellectual challenge, gratification by serving others, financial rewards and social status. Disillusionment begins early in medical training; however, the investment in the profession is so great as to severely threaten self-esteem should one be brash enough to quit. Consequently, when disillusioned with medicine, the physician simply ups the ante and perseveres until he or she achieves sufficient social status, financial success, a handful of grateful patients, or enjoys the occasional stimulation of intellectual challenge.

Overshadowing these benefits, however, are the threats of malpractice, the enormous debt associated with entry into medicine, the perceived need to maintain a lifestyle that compels a high income, the patients who are demanding and dependent, and the unending barrage of new information. Initial excitement soon becomes cynicism and fatigue.

The disaffected physician may attempt to nurture himself through new cars, spacious homes, attractive mistresses, fantasies of early retirement and, occasionally, substance abuse. Unfortunately, such a physician finds little sympathy in society for his plight. Ironically, the physician appears to have "made it," at least according to the traditional landmarks of our society. He has high social status and comes closest to financial security of any profession in this country. Making it for the disaffected physician, however, simply means having secured one's place on an unending treadmill.

Common stresses

The problem of the disaffected physician goes beyond the more dramatic problems associated with impairment. Relatively few of us are so impaired that our incompetence threatens the well-being of our patients. On the other hand, approximately 25 percent of us are likely to be depressed at some time during our lives. The majority of us will experience professional disaffection at some time.

I recently surveyed 22 non-patient physicians at a stress management workshop for physicians and their families. Among the stresses identified most frequently were:

1. The work of being a physician is so compelling as to leave little energy available for the demands of intimacy and support to the family.
2. Patients are so demanding and covertly or openly hostile as to induce a hostile state in physicians.
3. Physicians are ill-trained in coping with problem patients: the clingers, the demanders, the help rejectors, the deniers. The doctor often feels helpless. The helplessness soon yields to anger and the family is frequently the displaced target of the anger.
4. The physician's schedule is unpredictable. Weekends and evenings out are frequently interrupted by professional demands.
5. Many physicians convey an inability to disclose the specifics of their burdens to their spouses. This is particularly true in psychiatry where the demands of confidentiality prevent a detailed rendering of the patient-related stresses that the physician has experienced.
6. Most physicians acknowledge that they carry a burden of hostility around with them. The healthier among the survey respondents had set aside special times wherein they could drift off while alone, sheltered from the demands from any other person.

(References are available from the author)

help and involvement in these outlying societies.

The Physician Loan Fund was established by the Council to help in hardship cases where the previous impairment has resulted in a critical financial situation. This fund is administered by a subcommittee that carefully evaluates each case. Loans are limited to $5,000.

Student well-being

The Research and Development Subcommittee surveys trends and suggests new directions.

Medical student well-being subcommittees are the most recent addition to the program. Medical student representatives from each of the four medical schools in the state educate their peers regarding substance abuse and stress. This is a critical area in the whole impaired physician problem. Early case finding and treatment as well as mental health training will contribute greatly to an effective overall program.

There currently are discussions going on with the Michigan Osteopathic Association relative to its officially joining with our Program to Assist Impaired Physicians. In actual practice we already have extended our services to osteopathic physicians.

Our system, called diagnostic intervention, is characterized by a very flexible approach and by an accepting, non-judgmental attitude combined with a strong desire to help.

The general format is to start the intervention on a low key and explore the situation first, the first priority being to establish a trusting, therapeutic relationship. This is the intervenor's most effective tool.

The best way to accomplish this seems to be first to describe the purpose and function of the health and well-being committee, to allay the doctor's fears about confidentiality and possible connection with any disciplinary body.

It is pointed out that the Committee keeps no written records, and that it is there only to help. It is explained that a report has come to the committee about the MD and that help is needed to understand it. An appeal for cooperation and trust is made, which results in the physician's help as co-investigator.

This is not just a ploy — the doctor's help is needed. He or she will be a most important source of information and one must encourage participation as deftly as possible. Once this has been achieved the intervention is off to a productive start.

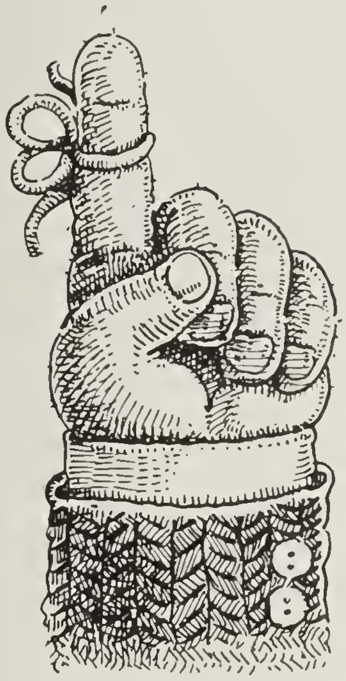
Overcoming the doctor's denial of illness will be the main initial task. This is accomplished by making use of the therapeutic relationship and building on the knowledge and diagnostic skills of intervenors.

Peer pressure is the second persuasive element of this system. The fact that the health and well-being committee speaks for organized medicine is not lost on the impaired physician. "Being a doctor" is deeply set in the psyche. It is a life-long endeavor and is frequently the most important thing in life. Most doctors are acutely tuned to gaining approval of their colleagues and to avoiding things which might bring on disapproval.

Intervention is usually not just a one-shot deal. It may involve continuing contact with the troubled doctor, possibly collecting further information, seeing that the suggested treatment program is carried out, maintaining contact with the spouse, therapist or AA Sponsor. It may involve a bit more pressure. The therapeutic relationship that has been developed with the doctor will help to carry the intervenors through all this.

A final note might be added about general use of the program. Ninety percent of all the physicians in the state are covered by their own county health and well-being committee's services. The remaining 10 percent are in the smaller county societies and are more removed from the urban centers. They will come under the coverage of the central subcommittee for intervention.

In the first year of operation of our program, approximately one percent of MSMS members were contacted by our intervention teams — 57 percent of these were for alcohol abuse and 27 percent for drug abuse. The statistics for the second full year of operation are not in yet, but all indications are that we are getting to the problems and making an effective impact on them.



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Fifty percent of men, 97 percent of women never physically fit in their lives

By Joseph Arends, MD
Troy

Illustrations with this article are from the brochure, "Fitness For Youth," produced by Doctor Arends and cohorts at the University of Michigan.

In a free society mass communication can sometimes do more harm than good.

With the boom of preventive medicine and self-care, the public is being bombarded and confused by a myriad of wrong information and many self-proclaimed experts. For example, the three largest national sources of information for our school children are providing misdirection.

The President's Council on Physical Fitness and Sports has as its test sit-ups, long jump, pull-ups, 50 yard dash and 600 yard shuttle run. Yet none of these tests indicates the state of cardiovascular fitness of our youth. Secondly, the President's Council over the past 25 years has placed much more emphasis upon sports than upon fitness.

Doctor Arends is a specialist in general preventive medicine and a well-known Detroit-area fitness consultant.

The American Alliance of Health, Physical Education, Recreation and Dance is the national association of physical educators. This organization has basically adopted the same testing criteria for fitness and placed an over-emphasis upon sports. The title of their organization alone indicates the emphasis away from fitness and more towards recreation. Little time is spent upon such basic health principles as nutrition or exercise physiology.

Wrong, deceitful

The National Dairy Council receives approximately three-fourths of its budget from the American Dairy Association as a coerced contribution from farmers from the sale of their milk. The National Dairy Council preaches the philosophy of a balanced diet, the basic four, or food in moderation. All of these are wrong and deceitful . . . how could the National Dairy Council, which receives a majority of its budget from the sale of whole milk, possibly talk down the use of butter and cheese? It has an obvious bias. And data accumulated over the past 25 years show quite clearly that our fat intake is excessive and should be reduced.

Even more confusing is the information put out by magazines, publishing houses and television. A recent survey of magazine articles demonstrated that over 80 percent of articles on nutrition were false and misleading. The popular TV exercisers have no credentials, yet make pronouncements about health that are confusing. A recent Gallup poll shows that 50 percent of Americans still believe that three hours of bowling is physical fitness. In the area of fitness alone, the public is still confused between endurance training, weight lifting and calisthenics. First comes the question of why physical fitness is important. Let us examine the facts.

Because our nation depends too heavily upon sports and not upon basic physical fitness, by the age of 13, 97 percent of all school age children are cut from competitive athletic programs. Such activities as Little League baseball, football, or basketball appeal only to the already elite and well coordinated athlete.

As a result of this competitive system and as judged by testing of school children in Michigan, we find that 50 percent of our males are never fit their entire lives and over 97 percent of females are never fit their entire lives. We find that the average American male peaks at about the age

Continued on page 298

DESCRIPTION: Methyltestosterone is 17β-Hydroxy-17-Methylandrost-4-en-3-one. **ACTIONS:** Methyltestosterone is an oil soluble androgenic hormone. **INDICATIONS:** In the male: 1. Eunuchoidism and eunichism. 2. Male climacteric symptoms when these are secondary to androgen deficiency. 3. Impotence due to androgenic deficiency. 4. Post-puberal cryptochidism with evidence of hypogonadism. Cholestatic hepatitis with jaundice and altered liver function tests, such as increased BSP retention, and rises in SGOT levels, have been reported after Methyltestosterone. These changes appear to be related to dosage of the drug. Therefore, in the presence of any changes in liver function tests, drug should be discontinued. **PRECAUTIONS:** Prolonged dosage of androgen may result in sodium and fluid retention. This may present a problem, especially in patients with compromised cardiac reserve or renal disease. In treating males for symptoms of climacteric, avoid stimulation to the point of increasing the nervous, mental, and physical activities beyond the patient's cardiovascular capacity. **CONTRAINDICATIONS:** Contraindicated in persons with known or suspected carcinoma of the prostate and in carcinoma of the male breast. Contraindicated in the presence of severe liver damage. **WARNINGS:** If priapism or other signs of excessive sexual stimulation develop, discontinue therapy. In the male, prolonged administration or excessive dosage may cause inhibition of testicular function, with resultant oligospermia and decrease in ejaculatory volume. Use cautiously in young boys to avoid premature epiphyseal closure or precocious sexual development. Hypersensitivity and gynecomastia may occur rarely. PBI may be decreased in patients taking androgens. Hypercalcemia,may occur, particularly during therapy for metastatic breast carcinoma. If this occurs, the drug should be discontinued. **ADVERSE REACTIONS:** Cholestatic jaundice • Oligospermia and decreased ejaculatory volume • Hypercalcemia particularly in patients with metastatic breast carcinoma. This usually indicates progression of bone metastases • Sodium and water retention • Priapism • Virilization in female patients • Hypersensitivity and gynecomastia. **DOSAGE AND ADMINISTRATION:** Dosage must be strictly individualized, as patients vary widely in requirements. Daily requirements are best administered in divided doses. The following is suggested as an average daily dosage guide. **In the male:** Eunuchoidism and eunuchism, 10 to 40 mg.; Male climacteric symptoms and impotence due to androgen deficiency, 10 to 40 mg.; Postpuberal cryptorchism, 30 mg. **REFERENCE:** R. B. Greenblatt, M.D.; R. Witherington, M.D.; I. B. Sipahioglu, M.D.: Hormones for Improved Sexuality in the Male and the Female Climacteric. *Drug Therapy,* Sept. 1976. **SUPPLIED:** 5, 10, 25 mg. in bottles of 60, 250. Rx only.

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of 14 and slowly deteriorates for the rest of his life. The average American female peaks at the age of 12 with subsequent deterioration. The tragedy is that we allow this to happen.

No self-esteem

The greatest harm done to youngsters when cut from a sport team is the tremendous blow to their self-esteem. They appear to recover, but I guarantee that their personalities are forever scarred. For the rest of their lives they perceive themselves as being inferior, insecure and inadequate as compared to their peers. These feelings pervade their whole personality for the rest of their lives.

Subsequently, if these youngsters achieve no measure of self-esteem in physical activity and if there is no alternative to fill the void, they will find alternatives in alcohol, tobacco and drugs. It is not just coincidental that 50 percent of smokers start before the age of 13. It is not just coincidental that the use of alcohol and drugs begins in the early to mid-teens because of lack of any other positive lifestyle. It is not just coincidental that overt crime behavior also begins at this time.

An interesting experiment in Deerfield, Illinois demonstrates a more immediate payoff of proper physical education. The people in this community were dealing with recurrent crime in teenagers. They found the startling realization that if they presented a positive alternative lifestyle the crime rate went down. This positive lifestyle was backpacking, hiking, and canoeing.

Unfortunately, parents become concerned with the crisis of alcohol abuse, drug abuse, obesity, tobacco usage and crime too late. They become concerned when the child is 16 or 18 years of age with an immediate crisis at hand. For the most part it is already too late. You must start at ages seven and 10 to have any major impact upon personality development. If Deerfield, Illinois found a reduction in crime, we found a reduction in drug usage in the Fort Worth school district with our physical education between 1970 and 1972.

Athletic myths

The immediate payback not only is self-esteem, self-image and the avoidance of self-abuse; there also is the consideration of life and death.

Few people recognize or care to admit that the number one cause of death for American males in this country at the age of 30 is heart attack. Heart attack is a disease of childhood. Cholesterol plaque inside coronary arteries can be demonstrated at autopsy at the age of 10.

The case of Arthur Ashe, a world famous tennis pro who was not smoking, had a normal blood pressure and had a coronary at the age of 35 speaks clearly and loudly. If somebody had given him the proper dietary direction at the age of 10, his heart attack could have been prevented.

His case also is an example of the common athletic myth that high levels of physical fitness or high levels of endurance training will lower blood cholesterol. No amount of fitness will lower blood cholesterol, and there is no threshhold of fitness that will prevent a heart attack. At best, high levels of fitness will only retard a heart attack and improve survival.

A physical education program that we have developed at the University of Michigan called *Youth For Fitness* is a basic program that deals with physical fitness for all. This is a program built upon basic fitness, then intramurals and lastly inter-scholastic sports at the top of the pyramid.

We also firmly believe in the concept of an unbalanced diet of low fat, low salt and moderate sugar. Teaching children about their bodies, to inspire positive well being, is a much better alternative than allowing children to drift into a life of self-abuse.

The United States has more avoirdupois per capita than any other nation in the world. We are one of the leaders in coronary heart disease and we are one of the world's most unfit nations. In spite of the President's Council we have probably regressed in our youth's fitness over the past 25 years.

Yet, all of these problems are reversible if we change our educational philosophy.

Better alternative

So much of our world is dedicated to academic achievement and materialistic success. I question the unbalanced approach of our educational institutions. Our whole educational experience is career, achievement, money and fame.

Of what real value is that direction when you realize that 25 percent of all physicians are either alcoholics or drug addicts? Nobody speaks of personal time or family time or a balanced lifestyle for the professional.

My practice consists of physicians, dentists, lawyers, and self-employed businessmen who are commonly workaholics, working 60-80 hours per week. They are poor fathers, poor husbands, have high divorce rates and are commonly unhappy.

There is more to life than just career. There is the total development of mind, body and spirit. This concept is not new. The Greeks said it 2,000 years ago. The YMCA rediscovered it in 1840 but we have somehow forgotten that message over the last 50 years.

It is time to realize that education is more than just a cup to fill with technology. It implies our intellectual achievement, an ethical code of conduct and our physical well being.

These all are equal priorities, but we have forgotten this common sense logic. If we choose not to educate our total being, we will continue to condemn future generations of Americans to a life of self-abuse.

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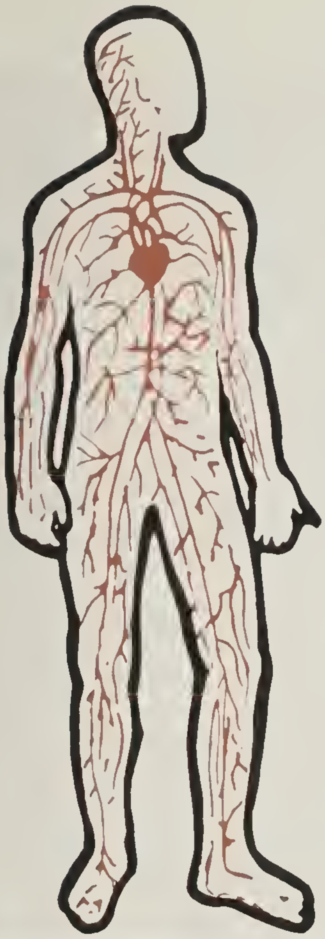
MSMS members visit Lansing

On the floor of the Michigan Senate, as testimony proceeds in the background, MSMS member Lars Kleppe, MD, Petoskey, confers with Sen. Mitch Irwin of Sault Sainte Marie. Doctor Kleppe was in Lansing under the auspices of the MSMS Physician Legislative Network, which provides legislators and physicians with greater insight into each other's work.

Also visiting Sen. Irwin that day was Ian Wilson, MD, of Petoskey. Both physicians are with the Burns Clinic Medical Center.

The MSMS legislative program also brought together physicians and lawmakers at recent receptions for the new, 1983 legislatures. After the reorganization of the elections, these receptions were held at MSMS headquarters. At right are Doctor and Mrs. Gerald Conway, left, Royal Oak and Rep. Wilbur Brotherton (R-Farmington).

Meeting at MSMS with his legislative counterpart is E. Joseph Alberding, MD, right, Portage, chairman of the MSMS Public Health Liaison Committee, The Representative is David Evans, (D-Mt. Clemens), chairman of the House Public Health Committee. Any MSMS members interested in greater legislative involvement may contact Kevin Kelly at MSMS headquarters.



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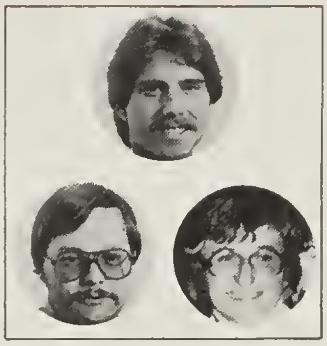

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Medicaid cost containment: Long term care reimbursement

By Robert J. Buchanan, PhD
University, MS

As long term care expenditures absorbed 37 percent of the Medicaid budget in Michigan during 1980, cost savings on nursing home reimbursement would have a significant impact on the containment of total Medicaid outlays. This study compares various reimbursement practices used by the Medicaid program in Michigan with the results of a national study of state Medicaid programs. We discovered that the payment mechanism used by Michigan is associated with cost containment while protecting the quality of care delivered. One important discovery was that Medicaid recipients in Michigan use higher priced skilled care at greater rates than do Medicaid recipients in the industrial Midwest region or the nation as a whole. If the skilled/intermediate care patient days mix in Michigan approached the average for the nation, then the state's Medicaid expenditures would have been reduced by over $3.6 million during 1979.

The Research Institute of Pharmaceutical Sciences (RIPS) at the University of Mississippi conducted a national study of state Medicaid programs to determine the impact various reimbursement factors have had on the cost and use of long term care between 1975 and 1981. A series of survey questionnaires were mailed to all the state programs to gather data on per diem payments and reimbursement factors used for both skilled and intermediate care. State utilization data for both types of care* were obtained from the Health Care Financing Administration of the Department of Health and Human Services. This study compares the Michigan program to the findings for the nation. Given the fact that long term care expenditures absorbed 37 percent of the Medicaid budget in Michigan during 1980, cost savings on nursing home reimbursement would have a significant impact on efforts to contain total Medicaid outlays.

Reimbursement factors

The RIPS national analysis of reimbursement factors used by state Medicaid programs to pay for long term care discovered that some of these mechanisms are associated with lower per diem costs. A discussion of these factors follows:

Return on net equity.

Federal regulations allow each state Medicaid program the option to treat "a return on proprietary providers' net equity" as an allowable cost when calculating payment rates. The Department of Social Services (Medicaid) in Michigan permits proprietary providers to select between two options for a profit factor. One option involves comparing the allowable costs of an individual facility to the 80th percentile cost of other institutions delivering the same class of care. If the cost of an individual facility is less than the 80th percentile cost, the provider receives the difference between the 80th percentile cost and the actual cost, not to exceed $1.50 per patient day.

The other option permits proprietary providers to be reimbursed according to Medicare's definition of return on net equity (RONE). Equity capital is defined as a provider's investment in plant, property, and equipment related to patient care (net of depreciation); funds a provider is required to deposit when plant, property or equipment related to patient care is leased (net of noncurrent debt related to such investment or deposited funds), and net working capital maintained for necessary and proper operation of activities related to patient care. The actual Medicare RONE rate was 15.188 percent for 1980.* According to officials in the Michigan Medicaid program, due to the low amounts of equity carried on the books of Michigan nursing homes, the return on equity option has not been a significant factor in Michigan Medicaid rates.

The national analysis of Medicaid programs revealed that states allowing RONE as a reimburseable cost paid significantly higher per diem rates for skilled care than states not allowing the reimbursement of RONE. These observed outcomes were also true for intermediate care rates although the differences were not as large as for skilled care. Medicaid recipients in states following the use of RONE as a reimburseable cost had greater access to skilled care but lower access to intermediate care, than did Medicaid recipients in states not allowing RONE. The treatment of this reimbursement factor by the Michigan Medicaid program is associated with lower per diem rates for nursing home care according to the conclusions of the national study.

Capital interest expenses

The survey of Medicaid programs conducted for the national study asked each state how interest expenses incurred by long term care facilities for capital indebtedness were treated for reimbursement purposes. Each state Medicaid program was

Continued on page 304

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* **Medicaid recipients 65 years and over.**

* **For a fiscal year ending June 30, 1980.**

Doctor Buchanan is research assistant professor, Research Institute of Pharmaceutical Sciences, School of Pharmacy, University of Mississippi.

DIMENSION III

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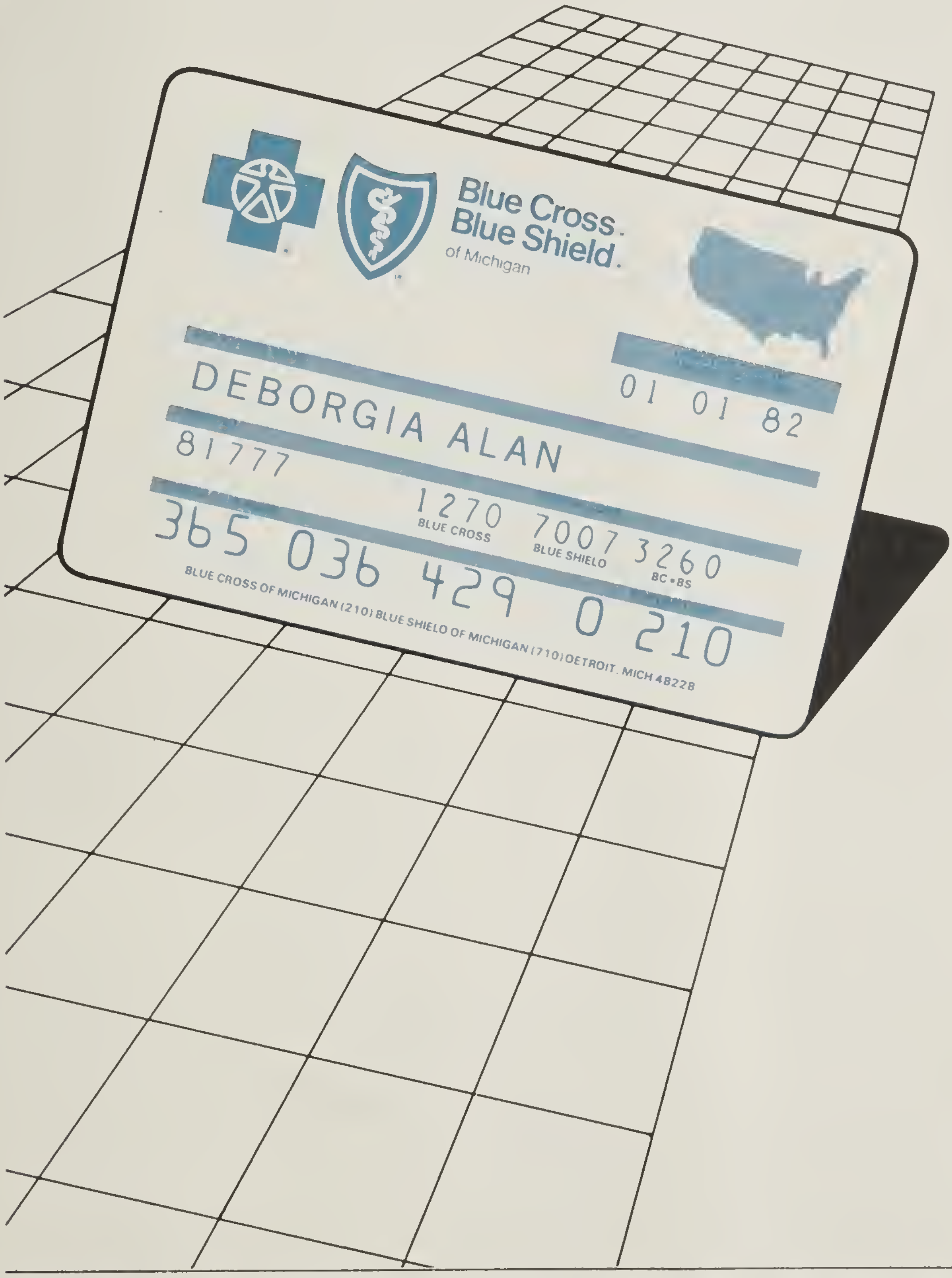
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Blue Cross and Blue Shield coverage is the choice of over 5 million Michigan residents. Why not make it your choice, too?
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given the following choices: not an allowable cost; full reimbursement of interest expenses; and, reimbursement of interest with a ceiling. All states responding used one of the latter two options. The Department of Social Services in Michigan places a ceiling on the amount of interest reimbursed, which is "based on the surveyed mean of interest rates paid and the mean asset values for facilities conducted during the three years surveyed."

The results of the national study indicate that states placing a ceiling on capital interest expenses averaged significantly lower payments for skilled care and to a lesser extent intermediate care. States placing a ceiling on capital interest expenses averaged higher use of skilled care but lower use of intermediate care than did states allowing full reimbursement. The treatment of capital interest expenses used by the Michigan Medicaid program is associated with lower per diem costs for long term care.

Inflation factor

The survey of Medicaid programs conducted for the national study asked each state what percentage rate was used each year as an inflation factor when calculating long term care reimbursement rates. The results of this national study indicate that higher inflation factors used in determining payments were associated with higher long term care costs to state Medicaid programs. The analysis also reveals that higher inflation factors did not result in greater access to care. The average inflation factor used in reimbursement for long term care by the various state programs was 11.97 percent in 1981, higher than the 7.5 percent average level used in Michigan. Results of the national study indicate this lower rate in Michigan helped hold down costs without adversely affecting utilization. During February of 1983 the Michigan Medicaid program used an inflation factor of 5.8 percent annual rate.

Percentiles

State Medicaid programs can use a percentile methodology when calculating new per diem rates for long term care. The first step in the percentile methodology is to classify providers according to the type of care delivered. Next the providers are rank ordered within each classification according to each provider's projected costs for delivering that type of care. This results in an ascending array of projected per diem costs. Finally, the provider at the x percentile level of this ascending array is selected and the projected per diem cost incurred by that provider serves as the Medicaid reimbursement rate for all institutions delivering that type of care. The percentile levels used by the state programs during 1981 to calculate new long term care rates ranged from a low of the 50th percentile to a high of the 90th percentile, with an average of the 69th percentile. The Michigan Medicaid program uses the 80th percentile level for both skilled and intermediate care.

One of the major findings of the RIPS national study was that between 1975 and 1981 states using the percentile methodology in reimbursement paid dramatically lower per diem fees for long term care (e.g., in 1981 it was $36.18 skilled care and $29.96 intermediate care), and Medicaid recipients experienced greater access to care, than did those in states not using the percentile methodology (where the average per diems in 1981 were $42.43 for skilled care and $33.18 for intermediate care). Focusing solely on those states using the percentile methodology, the results of the national study indicate that the actual percentile level was not correlated with skilled care costs but lower percentile levels were linked to lower intermediate care costs. The use of the percentile methodology in Michigan is associated with lower long term care costs, according to the results of the national study.

Prospective rate setting

Another important reimbursement factor concerns the timing for establishing payment rates. With prospective rate setting, the amount of the Medicaid payment is established prior to the period the fee will be in effect. With retrospective rate setting, the amount of Medicaid reimbursement is calculated after the care has been delivered based on the actual costs. Advocates of the prospective rate mechanism claim that it is an effective cost containment device, promoting the efficient delivery of care. Advocates of the retrospective mechanism assert that this method is necessary to provide Medicaid patients with access to care and also to assure good quality care.

The analyses for the national study discovered that between 1975 and 1981 state Medicaid programs using prospective rate setting paid consistently lower per diem fees for both skilled (e.g., 1981 — $38.11) and intermediate care (e.g., 1981 — $31.04) than did states using the retrospective mechanism (e.g., 1981 — skilled care $43.30, intermediate care $35.00). Contrary to the criticisms of the prospective method relating to access, Medicaid patients in states using the prospective method actually had greater utilization levels of both skilled and intermediate care than did states using retrospective reimbursement. To protect Medicaid recipients from the possibility that the use of prospective rate setting would lower the quality of care, the payment mechanism should be linked to a quality of care mechanism.

The Department of Social Services in Michigan can subject all providers of long term care to a variable quality of care penalty factor. The penalty is assessed against a provider's reimbursement rate, up to a maximum $1 per patient day, for failure to comply with certification standards. The Medicaid reimbursement system in Michgian uses prospective rate setting, which is associated with lower per diem costs, and commendably, also contains quality of care incentives.

Recommendations

The Department of Social Services in Michigan uses those reimbursement factors which the RIPS national study concludes are associated with lower per diem payments. Especially important is the use of the percentile methodology in a prospective rate setting system.

One possible cost containment reform in Michigan which should be considered would be to eliminate the return on net equity option used in reimbursement calculations. The national RIPS study indicates that states

Continued on page 307

Anxious patients improve in just a few days

And what is more reassuring to an excessively anxious patient than medication that promptly starts to relieve his discomforting symptoms? Valium® (diazepam/Roche) begins working within 30 to 90 minutes. Patients continue to improve in just a few days, and relief continues throughout the course of treatment.

There are other important benefits with Valium as well—along with its broad clinical range, Valium has an efficacy/safety profile that few, if any, drugs can match. This record has been achieved with extensive clinical experience, undoubtedly including yours. And, as you must have observed, side effects more serious than drowsiness, fatigue or ataxia rarely occur. Nevertheless, as with any CNS-acting agent, patients should be cautioned about driving, operating hazardous machinery or ingesting alcohol or other CNS-depressant drugs while taking Valium.

Yet another benefit Valium affords is flexibility. Available in 2-mg, 5-mg and 10-mg scored tablets, Valium enables you to titrate dosage to individual patient needs. For the geriatric patient, a starting dosage of 2 to 2½ mg once or twice a day is recommended. And, for patients who forget or skip medication, you can prescribe Valrelease™ (diazepam/Roche) 15-mg slow-release capsules, knowing that Valrelease will assure all the benefits of Valium 5 mg *t.i.d.* with the convenience of once-a-day dosage.

Discontinuation of Valium (or Valrelease) is typically as smooth as its start in short-term therapy. However, Valium and Valrelease should be discontinued gradually after more extended treatment. As you diminish dosage, the built-in tapering action of Valium and Valrelease will help avoid rapidly recurring anxiety symptoms and symptoms of withdrawal, and will help ease the patient's transition to independent coping when therapeutic goals have been achieved.

...that's one of the unique benefits of

Valium® (IV)
diazepam/Roche

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For a summary of product information, please turn the page. ROCHE®

Valium® (diazepam/Roche) Ⓝ Tablets
Valrelease™ (diazepam/Roche) Ⓝ slow-release Capsules
Injectable Valium® (diazepam/Roche) Ⓝ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. *Oral forms* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

> ***Usage in Pregnancy:*** **Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL. Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins,* i.e., *dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated)

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE. Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia.

In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL: *Adults:* Anxiety disorders, relief of symptoms of anxiety—Valium (diazepam/Roche) tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 to 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—tablets, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily.

Geriatric or debilitated patients: Tablets—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose.

Children: Tablets—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.)

For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., *dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children *administer I.V. slowly*; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

ORAL: Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500; Prescription Paks of 50, available in trays of 10; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25 and in boxes containing 10 strips of 10.

Valrelease (diazepam/Roche) slow-release capsules—15 mg (yellow and blue), bottles of 100; Prescription Paks of 30.

INJECTABLE: Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

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not allowing a return on net equity as an allowable cost averaged lower per diem payments for long term care than did states allowing RONE, without adversely affecting the willingness of the long term care industry to accept Medicaid recipients.

Cost analysis

The Department of Social Services in Michigan paid generally lower per diem rates for skilled care, and higher rates for intermediate care, than the average for Medicaid programs in either the Industrial Midwest region or the nation as a whole.

The national Medicaid reimbursement study discovered that health wage rates are strongly correlated with payments for long term care; higher wage rates are strongly associated with higher Medicaid payments. A health wage index was developed for the national study. During 1980, health wages in Michigan were 17.1 percent higher than the average for the nation and 10.7 percent higher than the average for the Industrial Midwest region. When higher health wage rates in Michigan are taken into account, Medicaid payments to nursing homes in that state compare favorably with the nation and region. Much of the credit for this cost performance can be attributed to the reimbursement system used by the Department of Social Services, based on the results of the national Medicaid study.

Utilization analysis

Medicaid recipients in Michigan are using skilled care at substantially higher rates and intermediate care at lower rates than the average for Medicaid recipients in either the Industrial Midwest region or the entire nation. During 1979 Michigan had 25.7 Medicaid patients per 1,000 elderly in skilled care facilities compared to 13.9 skilled care patients for the Industrial Midwest region and 14.4 skilled care patients for the nation. During 1979 Michigan had 22.6 Medicaid patients per 1,000 elderly in intermediate care facilities, whereas the average was 23.9 intermediate care patients per 1,000 elderly for the Industrial Midwest region and 30.0 intermediate care per 1,000 elderly patients for the nation. In terms of Medicaid patient days and average length of stay the results remain the same.

These utilization observations have important total cost implications given the higher Medicaid reimbursement rate for skilled care compared to intermediate care. Unless there is a medical reason to explain the higher than average use of skilled care by Medicaid recipients in Michigan, the state could save money by switching more patients to intermediate care facilities without denying them appropriate care. In Michigan there are almost twice as many Medicaid patient days in skilled care facilities per 1,000 elderly than there are in either the nation or the region. Conversely, there are fewer Medicaid patient days in intermediate care facilities per 1,000 elderly in Michigan than in the nation or the region.

If the mix of skilled care/intermediate care patient days in Michigan were to approach the average for either the industrial midwest or the nation, the potential savings would be substantial. For example during 1979 (the most recent year utilization data area available from HCFA), 52.8 percent of total Medicaid patient days for long term care in Michigan were in skilled care facilities compared to only 34.3 percent for the industrial midwest region and only 25.9 percent for the nation. If the percentage of skilled care patient days in Michigan approached the average of 34.3 percent for the region, then the cost savings would have approximated $2.5 million during 1979 ($1.25 million for the state). If the utilization mix approached the national average, then the cost savings would have been $3.6 million ($1.8 million as the state's share).

Summary

The Research Institute of Pharmaceutical Sciences at the University of Mississippi conducted a national study of reimbursement factors used by state Medicaid programs to pay for long term care. The study identified factors that are associated with lower payment rates but that do not adversely affect the access Medicaid recipients have to care.

The most important cost saving mechanism discovered was use of the percentile methodology in a prospective rate setting system, which the Michigan program uses.

The reimbursement mechanism for long term care used by the Michigan Medicaid program is one of the most progressive in the United States, encouraging both efficiency and the delivery of quality care. The payment system rewards efficiency by linking profit to the delivery of lower cost care. To protect the quality of care Medicaid patients receive, the Michigan Department of Social Services penalizes providers who do not comply with certification standards by lowering per diem payments.

The utilization pattern of skilled and intermediate care in Michigan is an area offering significant cost savings potential. Medicaid recipients are placed in skilled care facilities at much higher rates than are Medicaid patients on average in either the industrial midwest region or the nation.

In the absence of a medical need to explain these divergences from the national and regional averages, this study recommends that the Michigan program increase the number of intermediate care patient days while phasing in reductions of skilled care placements, until the use patterns approximate the averages for the industrial midwest region and the nation.

During 1979 this substitution would have resulted in a reduction of approximately $2.5 million in total Medicaid costs in Michigan and a savings of $1.25 million in state expenditures if the skilled/intermediate care patient mix had equaled the average for the industrial midwest region. The savings would be even greater, $3.6 million in total program costs and $1.8 million in state expenditures, if the use mix in Michigan approached the national average.

The cost containment strategies recommended for Michigan in this study must be viewed within the context of the day-to-day political and administrative environment. However, they warrant serious consideration for implementation either in their present or modified form.

Here are provisions of new drunk driving law

Michigan's stiffer new drunk driving laws, which went into effect in April, include the following major provisions. (The legislation was supported enthusiastically by MSMS.)

- Establishes a per se law which makes it illegal for anyone with a blood alcohol concentration (BAC) level of .10 percent or greater to operate a motor vehicle. It is expected that this provision will help increase convictions as it will not be necessary under the per se law to prove that a person was 'under the influence'; rather, it will only be necessary to show that the person had a BAC level of .10 percent or greater and was operating a motor vehicle in a public place. Penalties for conviction of per se violations are the same as for OUIL.
- Retains presumptive level for OUIL (operating under the influence of liquor) as at or above .10 percent BAC, and for OWI (operating while impaired) as above .07 percent BAC and below .10 percent BAC.
- Allows for the use of preliminary roadside breath testing equipment (PBTs) by law enforcement officers. This is expected to increase the number of arrests by providing law enforcement officers with more objective means of determining when an arrest is warranted. The results of the PBT cannot be used as evidence against the offender in court proceedings, but can be used to show that a valid arrest was made. Refusal to submit to a PBT would be a civil infraction.
- Mandates pre-sentence screening and assessment for all offenders to determine if they could benefit from participation in a substance abuse education or treatment program. Offenders will be required to pay the costs of the screening and assessment and to participate in an education or treatment program, also at their own expense, if ordered by the court. All screening and assessment programs are to be designated by OSAS.
- Establishes a 23-member drunk driving task force for two years to review all aspects of the drunk driving problem, including proposed and existing legislation, educational efforts, and law enforcement and judicial system activities.
- Requires the conduct of an annual drunk driving audit by the Michigan Department of State Police in cooperation with the Secretary of State, circuit and district courts and local units of government. The audit will be a far more comprehensive set of data than previously available, including statewide and county level information on crashes, arrests, court action and more.
- Increases license suspension penalties for OUIL convictions, and creates such penalties for OWI convictions.
- Increases the penalty for refusal to submit to the implied consent BAC test (the one required after an arrest) to include the addition of six points on an individual's driving record and a mandatory six month license suspension period.
- Allows Secretary of State to charge a $25 license reinstatement fee on suspended, revoked and restricted licenses.
- Allows for offenders with a previous OUIL conviction to be subject to second or subsequent offense penalties when charged with OWI.
- Requires the Secretary of State to revoke the license of a person convicted of two vehicle-related felony charges within seven years.
- Stipulates that restricted licenses may not be issued unless the person is unable to use public transportation and does not have anyone (family or otherwise) who could provide transportation. Offenders would be required to swear under oath that no such transportation was available. Also stipulates the purposes for which a restricted license could be used and requires that the permitted types of travel be indicated on the license itself.
- Disallows the issuance of a restricted license to anyone who has accumulated more than 24 points on their drivers' license within two years preceding the suspension.
- Allows chemical tests taken from samples of blood drawn for the purpose of medical treatment to be admissible as evidence whether or not the driver had consented to the test.
- Limits circuit court jurisdiction over appeals from persons who had their licenses suspended for refusal to submit to an implied consent test. This is achieved by stipulating that the circuit court may only review the record of the proceedings conducted by the Secretary of State to determine whether or not a proper disposition had been made.
- Makes it illegal to operate "under the influence of controlled substance," and allows evidence as to the presence of controlled substances in a person's body to be used as evidence in criminal prosecutions for OUIL, OWI and felonious driving, negligent homicide and manslaughter.
- Deletes the provision that blood samples taken on deceased operators may be used "for statistical purposes only."
- Allows police officers to submit written rather than sworn testimony at hearings held by the Secretary of State following appeal by offenders whose licenses were suspended after they refused BAC tests. This will result in cost savings by eliminating the need for getting testimony notarized.

The bills leave intact current jail and fine penalties for all offenses.

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J-9043-4 July 1981

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Each year, over one million American children suffer from child abuse. And over 2,000 children die from it.

But what about those who survive?

Statistics show that an abused childhood can affect a person's entire life.

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Yet child abuse *can* be prevented.

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We need your money. We need more volunteers.

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Because if we don't all start somewhere, we won't get anywhere.

National Committee for Prevention of Child Abuse

Help us get to the heart of the problem.

Write: Prevent Child Abuse, Box 2866, Chicago, Illinois 60690

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(BRIEF SUMMARY)

DESCRIPTION: Each tablet contains 200 mg meprobamate and 325 mg aspirin

INDICATIONS: Adjunct in short-term treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease Clinical trials demonstrated in these situations relief of pain is somewhat greater than with aspirin alone Effectiveness in long-term use, i e over 4 months, has not been assessed by systematic clinical studies Physicians should periodically reassess usefulness of drug for individual patients.

CONTRAINDICATIONS. ASPIRIN Allergic or idiosyncratic reactions to aspirin or related compounds MEPROBAMATE Acute intermittent porphyria, allergic or idiosyncratic reactions to meprobamate or related compounds, e g carisoprodol, mebutamate, or carbromal

WARNINGS: ASPIRIN Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes

MEPROBAMATE DRUG DEPENDENCE Physical and psychological dependence, and abuse have occurred Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo, Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e g anxiety, anorexia, or insomnia, or withdrawal reactions, e g , vomiting, ataxia, tremors, muscle twitching confusional states, hallucinosis, and, rarely, convulsive seizures Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation, symptoms usually cease within next 12-to-48-hour period When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn

POTENTIALLY HAZARDOUS TASKS Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e g., driving or operating machinery

ADDITIVE EFFECTS. Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of child-bearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they be-become pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.

Meprobamate posses the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels.

USAGE IN CHILDREN Keep preparations with aspirin out of reach of children. Equagesic®-M is not recommended for patients 12 years of age and under

PRECAUTIONS. ASPIRIN Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics

MEPROBAMATE Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney, to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function Meprobamate occasionally may precipitate seizures in epileptic patients It should be prescribed cautiously and in small quantities to patients with suicidal tendencies

ADVERSE REACTIONS: ASPIRIN May cause epigastric discomfort, nausea and vomiting Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur Patients receiving large doses of salicylates may develop tinnitus.

MEPROBAMATE CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity

GI. Nausea, vomiting, diarrhea

CARDIOVASCULAR Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate mebutamate and meprobamate carbromal. Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria and anuria Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis Stevens-Johnson syndrome and bullous dermatitis have occurred

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC") Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura

OTHER Exacerbation of porphyric symptoms

DOSAGE AND ADMINISTRATION: Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present Not recommended for patients 12 years of age and under

OVERDOSAGE: Treatment is essentially symptomatic and supportive Any drug remaining in the stomach should be removed Induction of vomiting or gastric lavage may be indicated Activated charcoal may reduce absorption of both aspirin and meprobamate Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported Acute simple overdose (meprobamate alone) Death has been reported with ingestion of as little as 12 gram meprobamate and survival with as much as 40 gram

BLOOD LEVELS:

0.5-2.0 mg percent represents usual blood-level range after therapeutic doses The level may occasionally be as high as 3 0 mg percent.

3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment Some fatalities occur

At levels greater than 20 mg percent, more fatalities than survivals can be expected

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol). Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels Any drug remaining in stomach should be removed and symptomatic treatment given. Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate Alkalinization of the urine increases excretion of salicylates Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration.

Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption

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Physicians in flight

Doctor Knoll: "Gliding is a solitary sport"

A glider pilot might be compared to a trout fisherman who uses only dry flies. He or she is a purist, a person who likes a challenge and is willing to take a risk.

Compared to more than 357,000 licensed power pilots in the nation, there are approximately 6,000 glider pilots, a mere handful of them Michigan medical doctors.

Bruce F. Knoll, MD, Jackson urologist, is one of these.

"Gliding is a more solitary sort of sport, an entirely different type of flying from a power airplane," he explains. "There are a number of different challenges in flying gliders."

Doctor Knoll is in a position to make the comparison because he has his commercial pilot rating, airplane single and multi-engine license; instrument airplane; seaplane license and glider (aero two) license.

Distinctly quiet

The only basic licenses he doesn't hold are to fly helicopters and balloons. He doesn't anticipate acquiring these now that he's discovered the joy of soaring.

"Gliding is distinctly quiet, he says. "Even balloons are noisy when you turn on the heat." The non-engine aircraft is so quiet and so peaceful, he adds, your mind can wander if you're not careful. And this can be hazardous to your health.

Looking at the sleek, two-place "Lark" glider, with its graceful, white body and long wings, it appears as though one could soar through the air with the greatest of ease. Not so!

"They can stall," Knoll points out quickly. "High performance gliders are very dangerous when it comes to stalling in a turn." He illustrated with his hands how the lower wing could begin to lose lift in a turn and the upper wing rolls up. There is no motor power for a pilot to rely on in a situation like this.

Gliders are launched by towing them behind an airplane (aero two); towing them with a winch and long cable (winch tow); or by towing them behind an automobile (auto tow).

Continued on page 318

Doctor Knoll describing glider's flight.

Ultralight pilot flies by seat-of-his pants

Ultralightist Dinkel gives author Weddon feel of the craft.

Some Michigan physicians who have a yen for flying but don't want to invest heavily in time or money, are turning to ultralights.

These little flying machines look like overgrown tricycles with 32-foot, colorful dacron wings on top. They're powered by a modified snowmobile motor which turns a small propeller.

The first ultralight was created in March 1975, when John Moody attached a 10 horse power motor to a hang-glider and flew about a quarter of a mile, southwest of Milwaukee, WI. Since that time the number of ultralight planes has increased until there are an estimated 20,000 in the country today.

They're used for aerial photography, law enforcement, crop spraying, and are being tested for possible military use. Recreation has been their chief attraction, however, and they now have floats for landing on water and skis for landing on snow.

Seat-of-the-pants

To fly a basic, weightshift ultralight, the engine is started with a pull on the cord. The pilot, wearing a helmet and held in a swinging harness-type seat by a safety belt, can maneuver the plane into take-off position by moving his feet on ground.

Then he flies, in airforce lingo, by the seat of his pants. Lean back and the plane goes up, lean forward and it comes down. Shift to one side and make a turn. Hold steady and soar, with or without the motor running. Stabilizing his weight is the secret.

Kits can be purchased for approximately $4,000 on up, and an ultralight can be assembled in about a day. It also is possible to learn to fly by self-instruction. But responsible dealers include instruction, which generally requires about two hours, in their selling price.

No license is necessary for either pilot or plane. The Federal Aviation Authority (FAA) has issued certain rules regarding ultralights, but has left the promulgation of safety programs to the ultralight community itself, as the primary use of the planes is for recreation.

The little planes can't travel more than 55 miles an hour at top speed and when the motor is turned off they can soar for more than a mile. They can fly low and slow, but don't go up when the wind is more than 20 miles an hour. It takes about 1.3 gallons of fuel to operate an ultralight while the motor is on.

Backyard take-offs

It is possible to take off on a 60-foot runway and land in a 100-foot area or less if the plane is equipped with brakes. This enables families to fly in and out of their back yards.

There were about 20 deaths in 1981 from ultralight accidents, according to unofficial estimates, and half of these were attributed to lack of pilot experience.

R. Douglas Dinkel, president of Ultralight Sport Flying, Inc., Lansing, points out that it is a safe sport when pilots are properly trained. Dinkel and three brothers operate an airpark southeast of Lansing, near Webberville. They sell ultralight kits, assemble them, fly them and train others.

"If you assemble your own, we inspect it and flight test it before you go up," he said. "It's also mandatory we train a pilot. Otherwise, it could be dangerous."

"We've had more than 175 students and haven't had a single injury," he continued. "We operate the airpark using the same control patterns regular airports have."

The Dinkels, with the largest airpark of this type in the state, have 140 acres of flatland where landings can be made from any direction if necessary. With a sky unbroken by high tension wires, the ultralights can fly at 300 feet or lower, well below the 500 feet altitude they maintain otherwise.

While some airplane pilots shudder at the thought of the growing number of ultralightists, there are many would-be pilots who anticipate the day when there will be an ultralight in every garage.

More on page 316

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Doctor Hall's balloon used in Cancer Society crusades.

He may be 'Mad John Hall,' but he likes his sport 'quiet and beautiful'

By Willah Weddon
Stockbridge

He's Captain John Hall when he's flying his balloon, Doctor John Hall while on duty at Health Central, Inc., Lansing, and Mad John Hall, according to his calling card.

Whichever title he happens to be using at the time, John C. Hall, MD, pulmonologist and internist, is enjoying himself. Piloting a balloon, however, is his special love.

"You're in the air, just flying along," he says. "There's no sense of motion whatever, it's entirely different . . . quiet and beautiful."

Doctor Hall, a 1969 Wayne State University Medical School graduate, had completed an internal medical residency at St. Joseph Mercy Hospital in Ann Arbor and begun a pulmonary disease residency at Wayne in connection with the University of

Michigan Medical School when he became interested in ballooning. His mentor was Nancy Furstenberg, MD, daughter of the late Albert C. Furstenberg, MD, Dean of the Michigan Medical School.

"Nancy knew Bill (William) Grabb, MD, and often said I should look him up," Hall recalled. "So I made his acquaintance, watched him fly and that's what really got me interested in ballooning."

Doctor Grabb, now deceased, is considered the grand-dad of balloonists in the country. He founded the organization of balloonists in the early 1960's, Hall explained, when equipment wasn't standardized and there was no certification by the Federal Aviation Association (FAA).

Half-dozen MDs

When Doctor Hall started flying, there were only 300 balloon pilots in the nation; today the number has risen to more than 3,000. He estimates there are 100 licensed balloonists in Michigan though not more than half-a-dozen of these are medical doctors.

When the six-foot, three-inch, red-haired dynamo began medical practice in Lansing in 1969, he was racing motorcycles, snowmobiles, automobiles, and sailing, as well as ballooning. (He's raced in the tornado class of Catamarans.) Five years later he also obtained his commercial pilot's license.

In 1972, a quirk of fate and a township ordinance prompted him to enter the balloonist business in earnest. Hall likes signs, or "graphic representations," and tacked one reading "Hodaka Motorcycles" on his garage. The Tacoma Hills Neighborhood Association accused him of violating a township ordinance and hauled him into court. Coincidentally, at the same time they also charged Wilford Maldonado, MD, a neighbor, for having erected a decorative fence around his home. (Doctor Maldonado is chairman of the MSMS Committee on State Legislation and Regulations.)

The two physicians acted as their own attorneys and Hall's suit was dismissed. "But Will counter-charged, saying the association was illegally chartered and constructed," Doctor Hall chortled at the memory. "He took the homeowners association right off the books. It was declared an unconstitutional organization.

Doctor Hall at balloon controls.

"The cases generated a lot of publicity and I decided this would make a good springboard to get into the balloon business," Hall grinned. He bought his own balloon, named it Hall's Ball and went into the "Ballooney Tunes" business with a partner. They offered "total aerostatic capabilities," consisting of commercial ascensions, flight instruction, rides, promotions and a variety of other services, including the sale of Raven balloons.

Ballooney tunes

Within a year Hall was flying his balloon in a continuing business arrangement for the local radio station, WVIC. "We've also done a fair amount of flying for the Cancer Society," he said. "That's where we got the 'No Smoking' balloon which we designed here in Lansing." He operated it for a year and now it is being flown in the Grand Rapids area under new ownership.

During the past 10 years Hall has flown 400 hours, averaging 10 to 20 flights a year. He and a four or five person crew fly as far as the wind will take them in an hour or two. The most they've traveled is 25 miles in one day.

Vertical movement in flight is controlled by the pilot but horizontal movement is dependent on the wind,

BALLOON/*Continued*

making ballooning as much an art as a science. As the air in the balloon cools, it begins to descend. Then the BTU/hr burners are turned on, throwing flames into the cavity of the balloon, reheating the air, and up it goes again. A height of two miles is not uncommon. To return to earth, a vent can be operated to allow hot air to excape in controlled amounts.

Experience counts

"Ballooning is a safe activity when the craft is operated by an experienced, well-trained pilot," Hall contends. A pilot must take 10 hours of instruction and pass a written examination as well as a flight test with FAA examiners to obtain a private license.

The first manned flight in a hot air balloon was made in France, November of 1783. An American doctor, John Jeffries, made the first recordings of air pressure at great heights a year later. Jeffries and another balloonist made the first flight across the English Channel in a hydrogen balloon.

It wasn't until the 1960's, when Raven Industries of South Dakota began manufacturing commercially saleable hot air balloons that ballooning became a practical sport.

A balloon costs from $5,000 to $15,000, depending on size and "extras." It costs about $125 an hour to operate a balloon, Hall said, and other basic equipment includes a truck and trailer for hauling. Storage is not a factor since the balloon folds into a cone-like tent on a trailer. There is upkeep on equipment and expense of an annual inspection, but he pointed out that with a crew sharing costs, it is less for an individual.

Although he's taken part in balloon festivals as far away as Albuquerque, Hall's favorite event is the annual Phogg Classic held each August in Flint in conjunction with the United Way Fund drive.

The Halls live in Williamston with their three children. Mrs. Hall, Bonnie, is a nurse-anesthetist at Sparrow Hospital, Lansing, and likes to go ballooning on occasion.

"I think she'd rather go sailing," 44-year-old Hall mused, adding, "Sailing and ballooning are quite similar. They both depend on the wind."

GLIDER/*Continued*

Uplifting sport

Once the plane is in the air, the pilot must use updrafts or "lifts" to remain aloft. These are generally found above parking lots and shopping centers, over plowed fields, hilly areas and other places where conditions create updrafts.

"The minute you hit a lift, you rise," Knoll explained. "When you're out of the lift, you go as fast as you can to lose as little altitude as possible until you hit another updraft."

The length of time you soar depends partly on the luck of finding necessary updrafts and skill in using them to the maximum. The average speed is from 40 to 70 miles an hour, although some "slick" gliders can go 100 mph, Knoll said. The wind factor is also important. "Too much wind will kill a lift, although some pilots fly on pretty windy days," he noted.

As he eased his six-foot, two-inch frame into the small confines of the cockpit, Knoll explained the equipment. There is a stick to control the ailerons and elevators, rudder pedals to control the rudder, and an instrument panel with a few basic gauges. The latter are activated by air sucked in through Pitot tubes on the nose of the glider.

A yaw string, an eight-inch piece of wool thread, mounted on top of the cockpit provides a visible guide to the amount of slipping or skidding a glider is doing while flying.

One shot

"When you land a glider, unlike a power plane, you get only one shot at it," the 49-year-old pilot pointed out. "We frequently send an airplane out at the end of the day to tow someone back from another airport because they couldn't find enough lift to get to their home airport."

If a pilot makes a landing in a field the glider can be dismantled and placed in a tubular trailer used for transportation back to the home hanger.

Doctor Knoll began flying while in the U.S. Army Chemical Service. He took private lessons and obtained his first pilot's license in 1956. Since that time, he's owned two and one-half airplanes (one in partnership).

In power airplane flying, however, expenses mount: $1.80 a gallon for fuel; an annual "physical," as Knoll describes it, at $500 on up; equipment repairs, insurance premiums and storage costs.

For the limited time he could spend flying, Doctor Knoll decided it was wiser not to own an airplane. But he still wanted to fly.

Gliders appeared to be an alternative. Last summer Knoll spent a week at the Black Forest Glider Port in Colorado Springs, Colorado, and received his license to fly them.

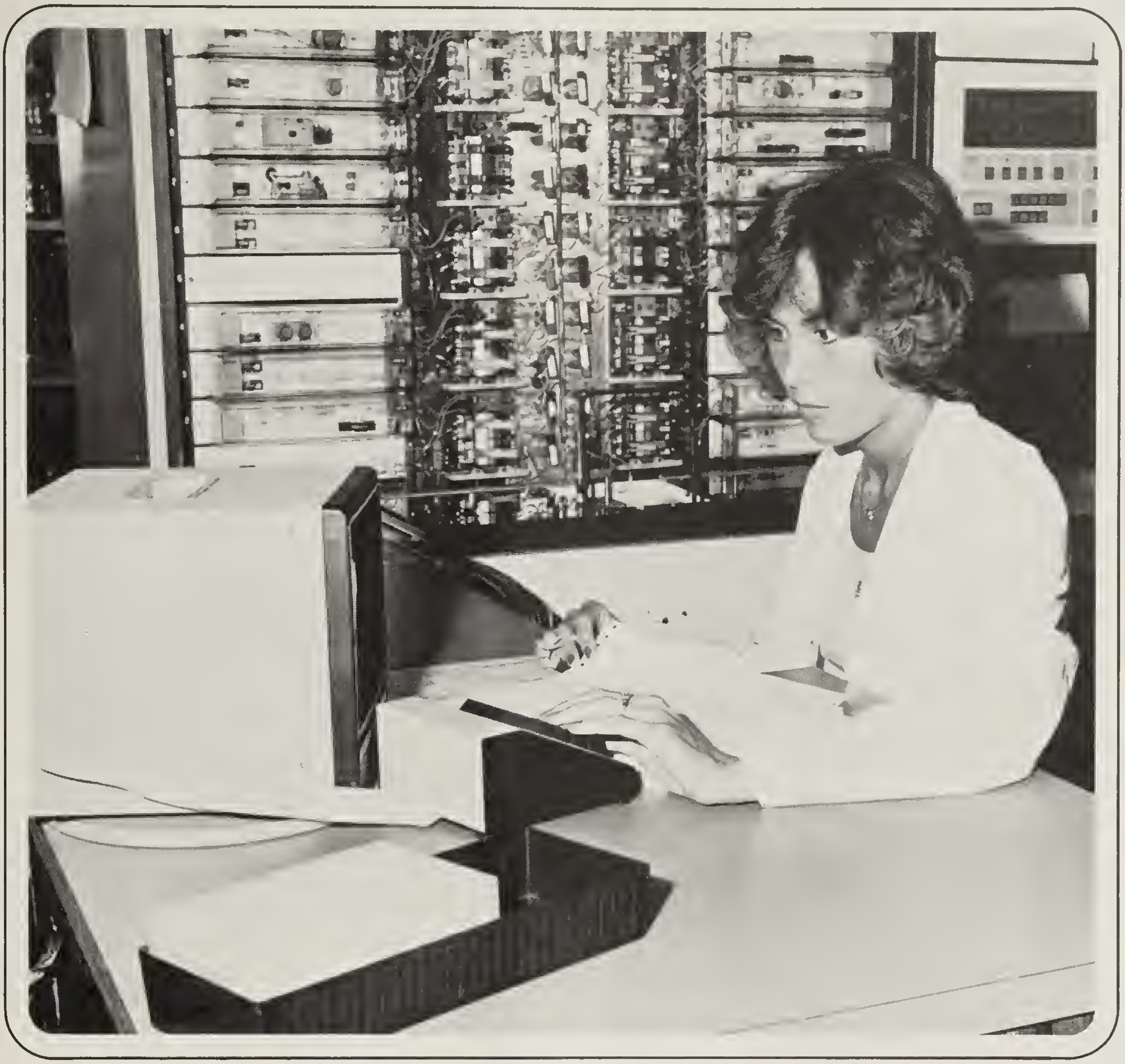
He joined the Napoleon Soaring Club, located three miles north of Manchester, MI. The club has four gliders, a tow plane, a winch and cable apparatus, and a hanger. With about 60 members, it is considered the largest soaring club in the state. Members pay monthly dues plus fees based on the amount of flying they do.

Doctor Knoll flies once or twice a month, "as time permits." The club is about 28 miles from Jackson where he lives with his wife, Lin, who also is a pilot with an instrument rating although she doesn't glide. The couple has one son, Matthew, a 15 year-old high school sophomore and a daughter, Susan, 17, who is a senior at Culver Girls' Academy.

Cost of a glider runs from $5,000 to above $40,000, for those in competition range. Several manufacturers sell build-your-own kits, which cost from $6,000 to $7,000, Knoll said, and they take about 400 hours to assemble.

To be licensed to fly a glider a person must pass a written test, following prescribed training, and pass a flight test with a flight examiner. A person licensed to fly power planes, as in Knoll's case, can make the transition with a minimum number of flights.

—**Weddon**



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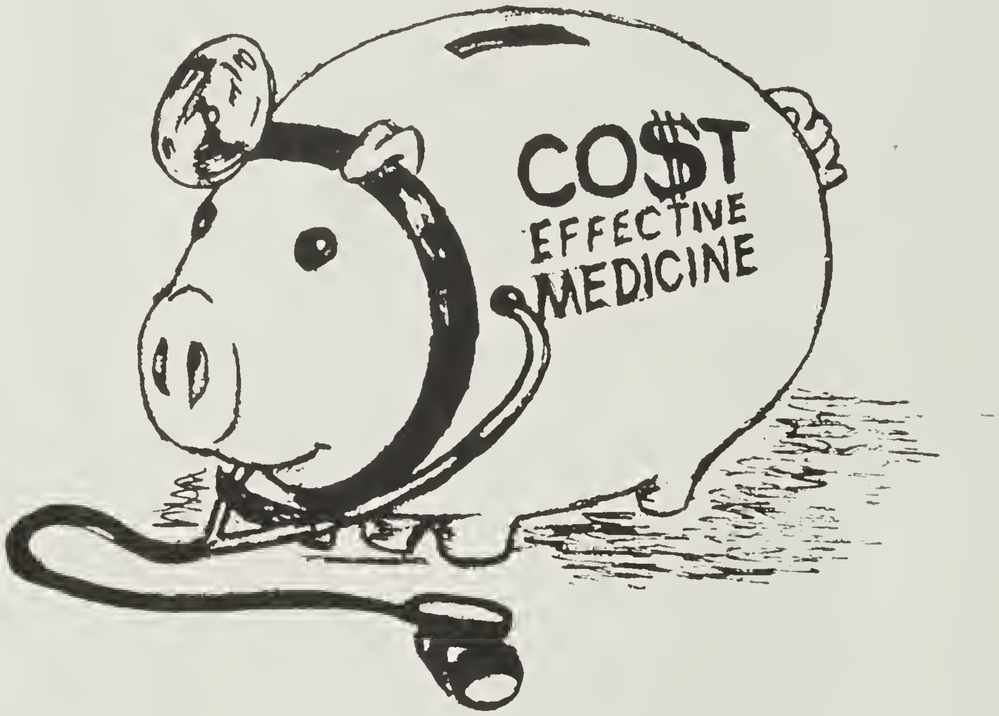
Won't someone turn down the lytes?

By R. Jack Chase, MD
Grand Rapids



Keeping a tight rein on medical costs should constantly be on the minds of all physicians.

We should remember that little things do add up. Let me give you a few figures, a little arithmetic to point this out. Someone, perhaps Jimmy the Greek, once said, "Figures don't lie, but liars can figure." I hope you will not feel that this applies here.

Too routine

For some time, I have felt that millions of medical dollars could be saved if we would turn down the "lytes." It has become an all too routine practice to order electrolytes on far too many hospital admissions as a routine order.

I, for one, do not feel that we need routine lytes on a relatively healthy pre-operative patient, not on diuretics, and in good fluid balance, and who is not a diabetic. I am not convinced that even acute myocardial infarctions who have not been on medication prior to admission need routine lytes.

We should be far more selective on the repetitive ordering of electrolytes, as well as the frequency of their order; indeed, we should be far more selective on the ordering of many of our laboratory tests.

Much of the time when we order lytes, we are really chiefly interested in the potassium. In the hospital where I practice, if one orders lytes, a sodium, potassium, chloride, and CO^2 are done and the cost is $20. If one of these tests is ordered singly, the cost is $5. If sodium or potassium tests are ordered singly, the cost is $5; but since they are doubly automated, both are reported. The hospital where I practice has approximately 540 beds. In December, 1982, certainly not the busiest month of the year, 2,300 electrolyte determinations were ordered. At $20 each, 2,300 tests cost $46,000 per month. If we assume, as I think we might, that 50 percent of these patients only needed a potassium test, we could save $17,250 per month. Multiply this by 12 months per year, and a saving of $207,000 is realized.

Also in December of 1982, 7,900 sodium and potassium determinations were run. You will recall that if only one is ordered, both are reported. If you assume that half of those were ordered as single sodium or potassium determinations, the cost would be 3,950 determinations at $5 each, equalling $19,750. The other half of the time if both were really needed, the cost would be twice that, or $39,500. Now, let's be more conservative here and say that these figures could be lowered by 25 percent each. Even then, a total savings of $177,744 a year would result.

In the same month of December, 1982, 6,000 chloride determinations and 5,200 CO^2 determinations were run at $5 each. If we assume that these, likewise, could be decreased by 25 percent, we would save another $168,000 per year.

Total savings

A total yearly savings of $552,744 per year would be realized on all these tests.

Now, assume that our hospital has only 500 beds. This would be a saving of $1,105 per bed per year.

According to the American Hospital Association, there are 1,077,728 general hospital beds in the United States. For figuring, let's assume a nice even 1,000,000 beds.

Let's assume that the hospital where I practice is similar to other hospitals across the country, and that a saving of $1,105 per bed could be made. Simply turning down the lytes could save $1,105,000,000 per year.

Won't somebody please turn down the lytes??

Doctor Chase, an internist, is chairman of the MSMS Task Force on Medical Care Costs.

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TEFRA and your retirement plan

By Dale E. Lamps, FSA
Grand Rapids

Mr. Lamps

Here is an overview of important changes for your retirement plan starting in 1983 and 1984.

The words "equity" and "responsibility" are interesting and attractive.

But in the title of the Tax Equity and Fiscal Responsibility Act of 1982 they are misleading.

The real meaning of TEFRA is that the Internal Revenue Service finally has its legislation to cut back on the use of retirement plans by professional corporations. Here is what TEFRA really means for your retirement plan:

- You cannot contribute as much on your own behalf.
- You have to contribute more on behalf of your employees.
- Your access to assets of the plan is more limited.

Here are some of the key changes applicable to most professional corporation plans, and how they achieve what the internal revenue service wanted:

Mr. Lamps is senior vice president with Watkins, Ross, Stanar and Lamps, the employee benefits consulting and actuarial firm headquartered in Grand Rapids. He is a fellow of the Society of Actuaries, a member of the Academy of Actuaries and author of many articles relating to the retirement plan field.

Summarized Change	Effective Date	Result to Physician
Loans from the plan to a participant cannot exceed $50,000 or half the value of vested benefits, if less.	August 13, 1982	Less personal access to plan assets.
Contribution limit reduced to $30,000 for profit sharing and other defined contribution plans (Formerly $45,475).	Plan years beginning in 1983.	Smaller contribution if income exceeds $120,000.
Benefit limit reduced to $90,000 for defined benefit pension (Formerly $136,425).	Plan years beginning in 1983.	Potentially lower current funding levels, as well as reduced final benefit.
Defined benefit limits scaled *down* from $90,000 for retirements under age 62 ($75,000 minimum at age 55 or over).	Plan years beginning in 1983.	Potentially lower current funding levels, as well as reduced final benefit.
Combined plan dollar limits reduced to 1.25 (Formerly 1.40).	Plan years beginning in 1983.	Further limitation for principals.
Integration with Social Security: contributions in excess of "covered compensation" reduced from 7 percent to 5.4 percent (defined contribution plans only).	Plan years beginning in 1983.	More benefits inuring to nonprofessionals.
Top Heavy Provisions		
Combined plan dollar limits reduced to 1.00.	Plan years beginning in 1984.	Further limitation for principals.
Minimum benefit accruals: Defined contribution — At least 3 percent annually. Defined benefit — At least 2 percent of pay times 10 years of service.	Plan years beginning in 1984.	More benefits inuring to nonprofessionals.
More liberal vesting: 1. 3 years eligibility, then 100% vesting, or 2. 1 year eligibility, then 0% first year and 20% per year thereafter; 100% in 6 years.	Plan years beginning in 1984.	More benefits inuring to nonprofessionals.
Distributions to "key employees" before age 59½ are subject to a special 10% additional tax.	Plan years beginning in 1984.	Earlier retirement discouraged.
Compensation limited to $200,000 for purposes of calculating benefits or contributions.	Plan years beginning in 1984.	Further limitation for principals.

The result? Pension and profit sharing plans as tax shelters are not as effective as they were in the past.

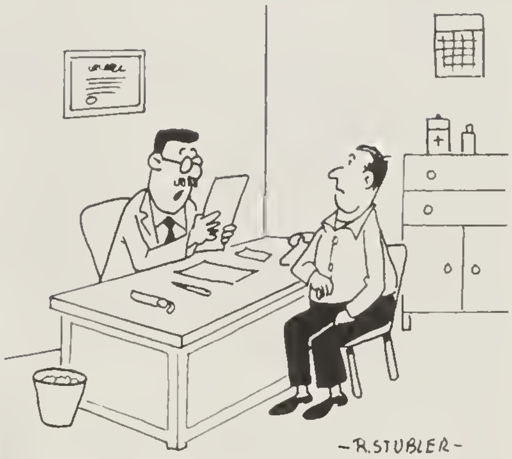
But, though you do not have as free a rein as in the past, retirement plans still are the most effective tax shelter available.

The key: Use knowledgeable professionals to design and run your plans, professionals who know how to get the most out of the new rules and who also know how to avoid running afoul of the rules.

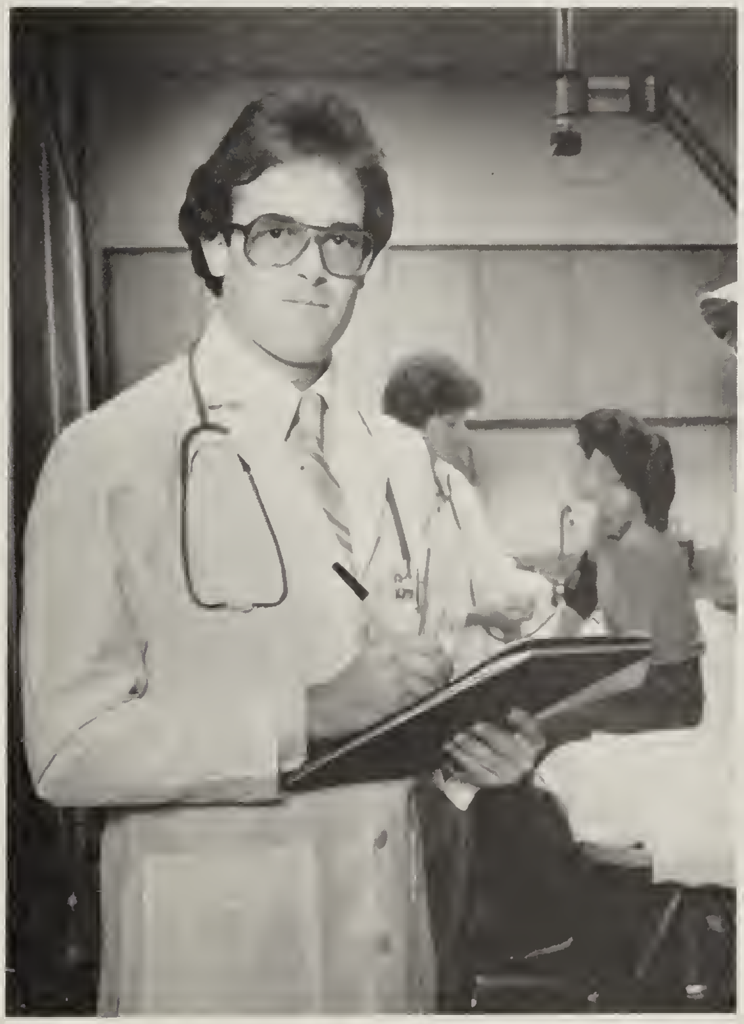
There are additional tools available to improve or supplement the retirement plan as a tax shelter. Examples are:

- Leasing of employees
- Severance benefits funded through a 501(c)(9) trust
- Retired life reserve death benefits
- Cafeteria plan for "medical reimbursement"

These will be discussed in subsequent articles.



"Your checks have more bounce to them than you do!"



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Book review

The law of medical practice in Michigan

By Michael D. Wade
Grand Rapids

The Law of Medical Practice in Michigan, Institute of Continuing Legal Education, Ann Arbor, 1982, $50.

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The practice of both law and medicine has become more difficult during the last decade. That increase in difficulty has been aggravated by deteriorating personal and professional relationships between doctors and lawyers, both of whom must deal with a geometrical increase in the complexities of their individual practices.

In the past, doctors and lawyers respected their individual realms of expertise, but as the interface between law and medicine grew, perceived infringements between the two disciplines developed not only into irritation, but also outright hostility.

The so-called malpractice crisis only aggravated the matter. Physicians felt that lawyers were second-guessing their treatment; lawyers saw a conspiracy of silence surrounding genuine malpractice claims to the detriment of injured persons seeking recompense. Ad hominem attacks by some members of both professions and lawsuits between them continued unabated until the present period of latency set in.

One significant contribution to an increased dialogue between doctor and lawyer is *The Law of Medical Practice in Michigan,* written by two attorneys and a medical doctor.

J. Douglas Peters, a partner in the firm of Charfoos, Christiansen, Gilbert and Archer, P.C., is no stranger to plaintiff malpractice cases and other aspects of medical-legal practice. Keith Fineberg is a former editor of the Lawyers Cooperative Publishing Co. and is currently a research attorney with COMLAW in Ann Arbor. Donald Knoll is both a medical doctor and a Ph.D. in pharmacology and is currently an assistant professor in the department of anesthesiology at the U of M School of Medicine. These men bring varying perspectives to bear and have produced a volume signaling the depth and intensity of their endeavor.

Published jointly by Health Administration Press and the Institute of Continuing Legal Education, both at the University of Michigan, the volume has as its stated purpose:

"... to serve as a reference and resource tool for physicians and attorneys engaged in the practice of medicine and law in Michigan ..."

The volume accomplishes that purpose and more.

The book was written exclusively for neither profession. The doctor will discover within its succinctly written 425 pages a wealth of information on his or her legal rights and obligations in relationships with hospitals, patients, society and the medical profession. The chapter on medical malpractice is a particularly concise statement of current Michigan law, including a treatment of physician countersuits.

The lawyer will come to appreciate the education, training, regulation and accountability of physicians in Michigan. For instance, attorneys, while licensed by the state and controlled professionally by the courts and certain administrative entities set up by the profession, often do not appreciate that physicians are subject to observation or control by many more entities.

Hospitals have staffing requirements and regulations intimately affecting medical practice; state statutes impose reporting requirements (e.g., child abuse, abortions, gun shot wounds, etc.); third-party pay organizations such as Blue Cross-Blue Shield and HMOs impinge on the doctor; and public accountability organizations such as PSROs review their activities.

It is fair to say that lawyers are not as regulated, observed, organized and methodized as are physicians. And atop all this, add courts and lawyers to those who would review the treatment rendered by a doctor, who has had little formal training in dealing with the law or lawyers, and less experience — usually distasteful.

The authors have not avoided the difficult issues. Topics such as abortion, contraception, genetic counseling and experimentation are discussed in the practical terms they deserve, rather than in a metaphysical void divorced from reality.

A lawyer is never faced with a situation like the following:

"With curable patients, the physician has an interest in curing them; with the terminally ill, the physician faces the problem of determining whether continued maximal efforts constitute a reasonable attempt to prolong life, or whether the patient's illness has reached a stage where further intensive care is, in fact, merely postponing an imminent death." (page 314)

The discussion involves principles of law and medical guidelines promulgated by medical associations. Answers are not always provided, since some questions require action, not answers. But by raising the questions, even without answers, the authors have treated sympathetically the immense weight of certain decisions physicians must make.

The book answers most questions it raises, and in so doing provides the attorney with a valuable research tool. It is well organized and tightly written, with accurate citations to appropriate and timely cases. In addition, rules, regulations and guidelines from competent medical associations are given in detail, providing little-known and little-used non-legal sources of authority.

Michael D. Wade is a graduate of the University of Toledo Law School. He is a member of the firm of Hillman, Baxter & Hammond, P.C., Grand Rapids, a medical malpractice defense firm.

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MEDICAL NEWSFRONTS

Flint's Genesee Memorial Hospital is one of few hospitals in the nation to purchase a **YAG laser**, a device to treat secondary cataracts.

Ten percent of the patients who have cataract surgery in the months and years to follow develop a decrease in vision, indicating the need for a second procedure.

With the YAG laser, a laser beam passes harmlessly into the eye and focuses energy to dissect the cloudy membrane. The YAG laser concentrates light energy into short intense pulses that create tiny openings in the membrane.

The YAG is a quick, effective, painless method of treatment. The patient has the procedure performed in a comfortable sitting position while remaining in street clothes and is allowed to leave the hospital with no restrictions following the procedure.

An estimated 60,000 Americans, most over the age of 60, annually require treatment for a cloudy membrane following cataract surgery. Using the YAG laser, there is a cost savings not only to the patient but to third party coverage with the elimination of the operating room expense.

The University of Michigan School of Public Health has received a five-year $454,000 grant from the Kellogg Foundation to establish **two new publications.**

To be published by the University's Health Administration Press (HAP), the first new work will be a journal to interpret and apply new knowledge obtained from health services research. The second will be a series of state-of-the-art papers on medical care organization.

The new quarterly journal will be called *Frontiers of Health Services Administration*. It will be a review journal carrying recommendations of particular interest to health care administrators. The series of papers on medical care organization will be carried in an expanded version of a current HAP quarterly publication, *Medical Care Review*. Topics currently under consideration for these papers are alternative delivery systems, new health care technology, and business and industry interests in health care. These topics will be coordinated, when feasible, with topics covered in Frontiers.

Two cases of **Reye's Syndrome** (RS) were reported in Michigan children from Ottawa and Monroe counties between February 26 and March 25. Both children were admitted at stage II. RS was preceeded by a respiratory illness in each child. A total of nine cases of RS, including one death, have been reported in Michigan since October 1.

Reports of nursing home and school outbreaks of influenza-like illness remain down in Michigan. All influenza virus isolates obtained by the MDPH virology laboratory have all been type A (H3N2) viruses.

Although the type A (H3N2) Bangkok-like influenza virus continues to predominate, type A (H1N1) England-like viruses have been obtained from 17 states and type B influenza viruses have been obtained from seven states to date this season.

In the Great Lakes Region, the following states have reported RS cases since October 1, 1982: Illinois (11), Minnesota (2), Ohio (15) and Wisconsin (2).

The neurology department of Harper-Grace Hospitals, Detroit, is adding a digital subtraction angiography unit, to enable the hospital to provide a complete range of services.

"We can respond to any request for consultation on an outpatient basis and we welcome the transfer of seriously ill patients or those with complex neurological problems," said John Gilroy, MD, chief of neurology.

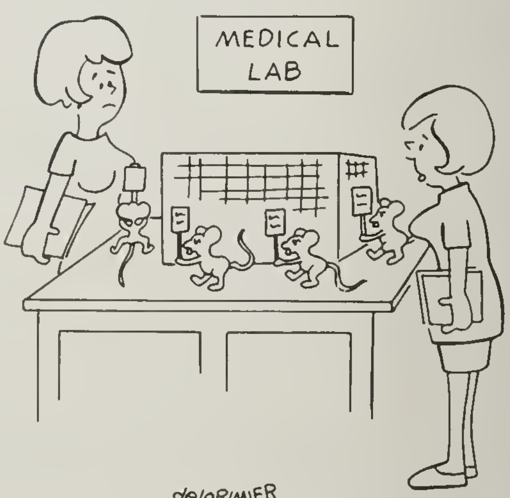
Harper-Grace has a six-bed intensive care unit designated, equipped and staffed for the care of neurology and neurosurgery patients. The unit is directed by Robert Ho, MD, a neurosurgeon. Harper-Grace also has three CT scanners. Its EEG laboratory also has state-of-the-art equipment and is directed by Kenneth Kooi, MD, who has an international reputation for achievement in his specialty.

University of Michigan Regents at their March 17-18 meeting gave the go-ahead for construction of the U-M Hospitals' $33 million **ambulatory care facility,** scheduled to begin June 1.

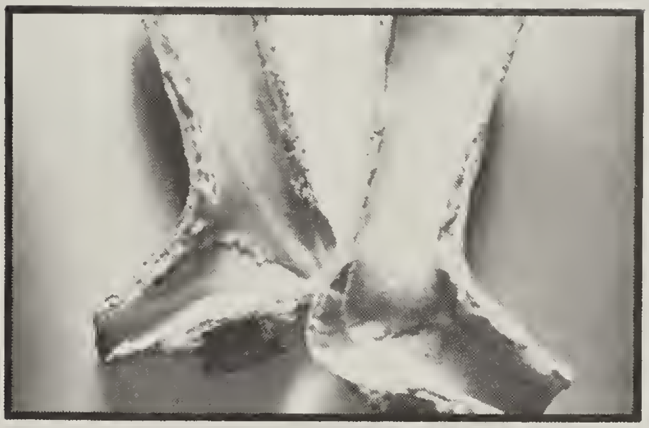
The ambulatory care facility is a central component of the replacement hospital project. It will accommodate approximately 200,000 visits per year in a pleasant, easily accessible, easily understood building.

The facility will house many of the hospitals' outpatient clinics and doctors' offices, and will feature a rooftop heliport for the hospital-based helicopter ambulance, a centrally located pharmacy and flexible clinic space that will accommodate large or small numbers of patients.

The ambulatory care facility is slated for completion in the fall of 1985.



"The mice are protesting. They want a say in the lab experiments."



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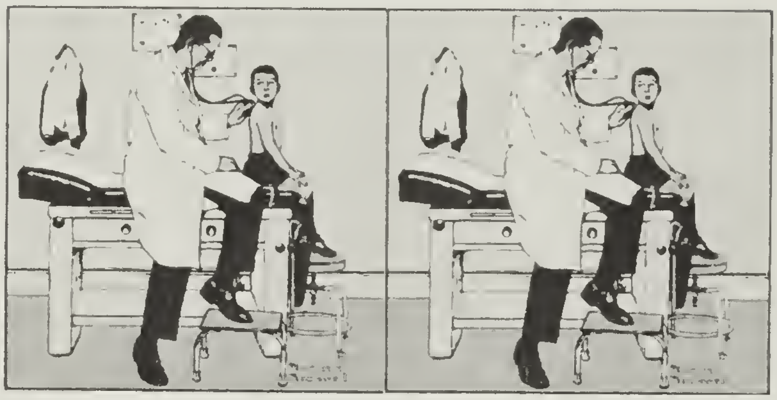
MSMS/A

Let's boost physician image

By Mrs. Norman Banghart
Ann Arbor



As the medical profession has, for some time, received disparaging publicity via the press and TV media, the MSMS Auxiliary has authorized the sale of a physician recognition stamp.

The stamp reproduces a drawing of a physician and young patient by the late Norman Rockwell, who was commissioned to do the drawing for the Massachusetts Mutual Life Insurance Company. The model for Mr. Rockwell was a physician-friend who practiced in Stockbridge, Massachusetts, where the Rockwell Museum is located. The drawing now is in the public domain — thus, there are no copyright restrictions. The stamp is used through the courtesy of the Auxiliary to the Medical Society of the State of New York.

This project is not intended as a fund-raising effort by MSMS/A, but rather as a positive effort to enhance the image of physicians. But MSMS/A suggests that county auxiliaries can make this a fund-raising project locally.

Thus two goals could be achieved — support both for local projects and for the state auxiliary endeavor to improve the present unjust image of the profession. The initial supply could be displayed on auxiliary meeting notices and invitations. We hope that county medical societies and individual doctors also will use these stamps on their official mailings.

If every county medical society and medical auxiliary would undertake this project, the cumulative efforts could be most gratifying.

The physician-image *can* be boosted with very little effort by using the physician recognition stamp on all mailings. The stamp, with its Norman Rockwell picture of a physician and his little patient, serves as a reminder that the majority of medical doctors are dedicated to serving humanity.

Requests for further information or orders for stamps may be directed to: Mrs. Norman Banghart, PRS Chairman, 3055 Geddes Avenue, Ann Arbor, MI 48104.

Mrs. Banghart is physician recognition stamp project chairman for MSMS/A.

References:
1. Stone PH, Turi ZG Muller JE Efficacy of nifedipine therapy for refractory angina pectoris *Am Heart J* 104 672-681, September 1982
2. Antman E, Muller J, Goldberg S, et al Nifedipine therapy for coronary-artery spasm Experience in 127 patients *N Engl J Med* 302 1269-1273, June 5, 1980

BRIEF SUMMARY
PROCARDIA® (nifedipine) **CAPSULES** For Oral Use

INDICATIONS AND USAGE: I. Vasospastic Angina: PROCARDIA (nifedipine) is indicated for the management of vasospastic angina confirmed by any of the following criteria 1) classical pattern of angina at rest accompanied by ST segment elevation 2) angina or coronary artery spasm provoked by ergonovine, or 3) angiographically demonstrated coronary artery spasm In those patients who have had angiography the presence of significant fixed obstructive disease is not incompatible with the diagnosis of vasospastic angina, provided that the above criteria are satisfied PROCARDIA may also be used where the clinical presentation suggests a possible vasospastic component but where vasospasm has not been confirmed, e g where pain has a variable threshold on exertion or in unstable angina where electrocardiographic findings are compatible with intermittent vasospasm or when angina is refractory to nitrates and or adeguate doses of beta blockers

II. Chronic Stable Angina (Classical Effort-Associated Angina): PROCARDIA is indicated for the management of chronic stable angina (effort-associated angina) without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and or organic nitrates or who cannot tolerate those agents

In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks duration in reducing angina freguency and increasing exercise tolerance but confirmation of sustained effectiveness and evaluation of long-term safety in those patients are incomplete

Controlled studies in small numbers of patients suggest concomitant use of PROCARDIA and beta blocking agents may be beneficial in patients with chronic stable angina, but available information is not sufficient to predict with confidence the effects of concurrent treatment especially in patients with compromised left ventricular function or cardiac conduction abnormalities When introducing such concomitant therapy care must be taken to monitor blood pressure closely since severe hypotension can occur from the combined effects of the drugs (See Warnings)

CONTRAINDICATIONS: Known hypersensitivity reaction to PROCAROIA

WARNINGS: Excessive Hypotension: Although in most patients the hypotensive effect of PROCARDIA is modest and well tolerated occasional patients have had excessive and poorly tolerated hypotension These responses have usually occurred during initial titration or at the time of subseguent upward dosage adjustment and may be more likely in patients on concomitant beta blockers

Severe hypotension and or increased fluid volume reguirements have been reported in patients receiving PROCARDIA together with a beta blocking agent who underwent coronary artery bypass surgery using high dose fentanyl anesthesia The interaction with high dose fentanyl appears to be due to the combination of PROCARDIA and a beta blocker but the possibility that it may occur with PRDCARDIA alone with low doses of fentanyl in other surgical procedures or with other narcotic analgesics cannot be ruled out In PROCARDIA treated patients where surgery using high dose fentanyl anesthesia is contemplated the physician should be aware of these potential problems and if the patient's condition permits sufficient time (at least 36 hours) should be allowed for PROCARDIA to be washed out of the body prior to surgery

Increased Angina: Dccasional patients have developed well documented increased frequency duration or severity of angina on starting PROCARDIA or at the time of dosage increases The mechanism of this response is not established but could result from decreased coronary perfusion associated with decreased diastolic pressure with increased heart rate or from increased demand resulting from increased heart rate alone

Beta Blocker Withdrawal. Patients recently withdrawn from beta blockers may develop a withdrawal syndrome with increased angina probably related to increased sensitivity to catecholamines Initiation of PROCARDIA treatment will not prevent this occurrence and might be expected to exacerbate it by provoking reflex catecholamine release There have been occasional reports of increased angina in a setting of beta blocker withdrawal and PROCARDIA initiation It is important to taper beta blockers if possible rather than stopping them abruptly before beginning PROCAROIA

Congestive Heart Failure: Rarely patients usually receiving a beta blocker have developed heart failure after beginning PROCARDIA Patients with tight aortic stenosis may be at greater risk for such an event

PRECAUTIONS: General: Hypotension: Because PRDCARDIA decreases peripheral vascular resistance careful monitoring of blood pressure during the initial administration and titration of PRDCARDIA is suggested Close observation is especially recommended for patients already taking medications that are known to lower blood pressure (See Warnings)

Peripheral edema: Mild to moderate peripheral edema typically associated with arterial vasodilation and not due to left ventricular dysfunction occurs in about one in ten patients treated with PRDCARDIA This edema occurs primarily in the lower extremities and usually responds to diuretic therapy With patients whose angina is complicated by congestive heart failure care should be taken to differentiate this peripheral edema from the effects of increasing left ventricular dysfunction

Drug interactions: Beta adrenergic blocking agents (See Indications and Warnings) Experience in over 1400 patients in a non-comparative clinical trial has shown that concomitant administration of PRDCARDIA and beta-blocking agents is usually well tolerated, but there have been occasional literature reports suggesting that the combination may increase the likelihood of congestive heart failure severe hypotension or exacerbation of angina

Long-acting nitrates PRDCARDIA may be safely co-administered with nitrates but there have been no controlled studies to evaluate the antianginal effectiveness of this combination

Digitalis Administration of PROCARDIA with digoxin increased digoxin levels in nine of twelve normal volunteers The average increase was 45% Another investigator found no increase in digoxin levels in thirteen patients with coronary artery disease In an uncontrolled study of over two hundred patients with congestive heart failure during which digoxin blood levels were not measured digitalis toxicity was not observed Since there have been isolated reports of patients with elevated digoxin levels it is recommended that digoxin levels be monitored when initiating adjusting and discontinuing PRDCAROIA to avoid possible over or under-digitalization

Carcinogenesis mutagenesis, impairment of fertility When given to rats prior to mating nifedipine caused reduced fertility at a dose approximately 30 times the maximum recommended human dose

Pregnancy Category C Please see full prescribing information with reference to teratogenicity in rats embryotoxicity in rats, mice and rabbits and abnormalities in monkeys

ADVERSE REACTIONS: The most common adverse events include dizziness or light-headedness peripheral edema nausea weakness headache and flushing each occurring in about 10% of patients transient hypotension in about 5% palpitation in about 2% and syncope in about 0 5% Syncopal episodes did not recur with reduction in the dose of PROCARDIA or concomitant antianginal medication Additionally the following have been reported muscle cramps, nervousness dyspnea nasal and chest congestion diarrhea constipation inflammation joint stiffness, shakiness sleep disturbances blurred vision difficulties in balance dermatitis pruritus urticaria fever sweating chills and sexual difficulties Very rarely introduction of PROCARDIA therapy was associated with an increase in anginal pain possibly due to associated hypotension

In addition more serious adverse events were observed, not readily distinguishable from the natural history of the disease in these patients It remains possible however that some or many of these events were drug related Myocardial infarction occurred in about 4% of patients and congestive heart failure or pulmonary edema in about 2% Ventricular arrhythmias or conduction disturbances each occurred in fewer than 0 5% of patients

Laboratory Tests: Rare mild to moderate transient elevations of enzymes such as alkaline phosphatase CPK LDH SGOT and SGPT have been noted and a single incident of significantly elevated transaminases and alkaline phosphatase was seen in a patient with a history of gall bladder disease after about eleven months of nifedipine therapy The relationship to PROCAROIA therapy is uncertain These laboratory abnormalities have rarely been associated with clinical symptoms Cholestasis possibly due to PROCARDIA therapy has been reported twice in the extensive world literature

HOW SUPPLIED: Each orange soft gelatin PROCARDIA CAPSULE contains 10 mg of nifedipine PROCARDIA CAPSULES are supplied in bottles of 100 (NDC 0069-2600-66) 300 (NDC 0069-2600-72) and unit dose (10x10) (NOC 0069-2600-41) The capsules should be protected from light and moisture and stored at controlled room temperature 59 to 77 F (15 to 25 C) in the manufacturer's original container

More detailed professional information available on request © 1982 Pfizer Inc

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"I can do things that I couldn't do for 3 yrs. including joining the human race again."

Quotes from an unsolicited letter received by Pfizer from an angina patient.
While this patient's experience is representative of many unsolicited comments received, not all patients will respond to Procardia nor will they all respond to the same degree.

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"My daily routine consisted of sitting in my chair trying to stay alive."

"My doctor switched me to PROCARDIA[*] *as soon as it became available. The change in my condition is remarkable."*

"I shop, cook and can plant flowers again."

"I have been able to do volunteer work...and feel needed and useful once again."

PROCARDIA can mean the return to a more normal life for your patients—having fewer anginal attacks,[1] taking fewer nitroglycerin tablets,[2] doing more, and being more productive once again.

Side effects are usually mild (most frequently reported are dizziness or lightheadedness, peripheral edema, nausea, weakness, headache and flushing, each occurring in about 10% of patients, transient hypotension in about 5%, palpitation in about 2% and syncope in about 0.5%).

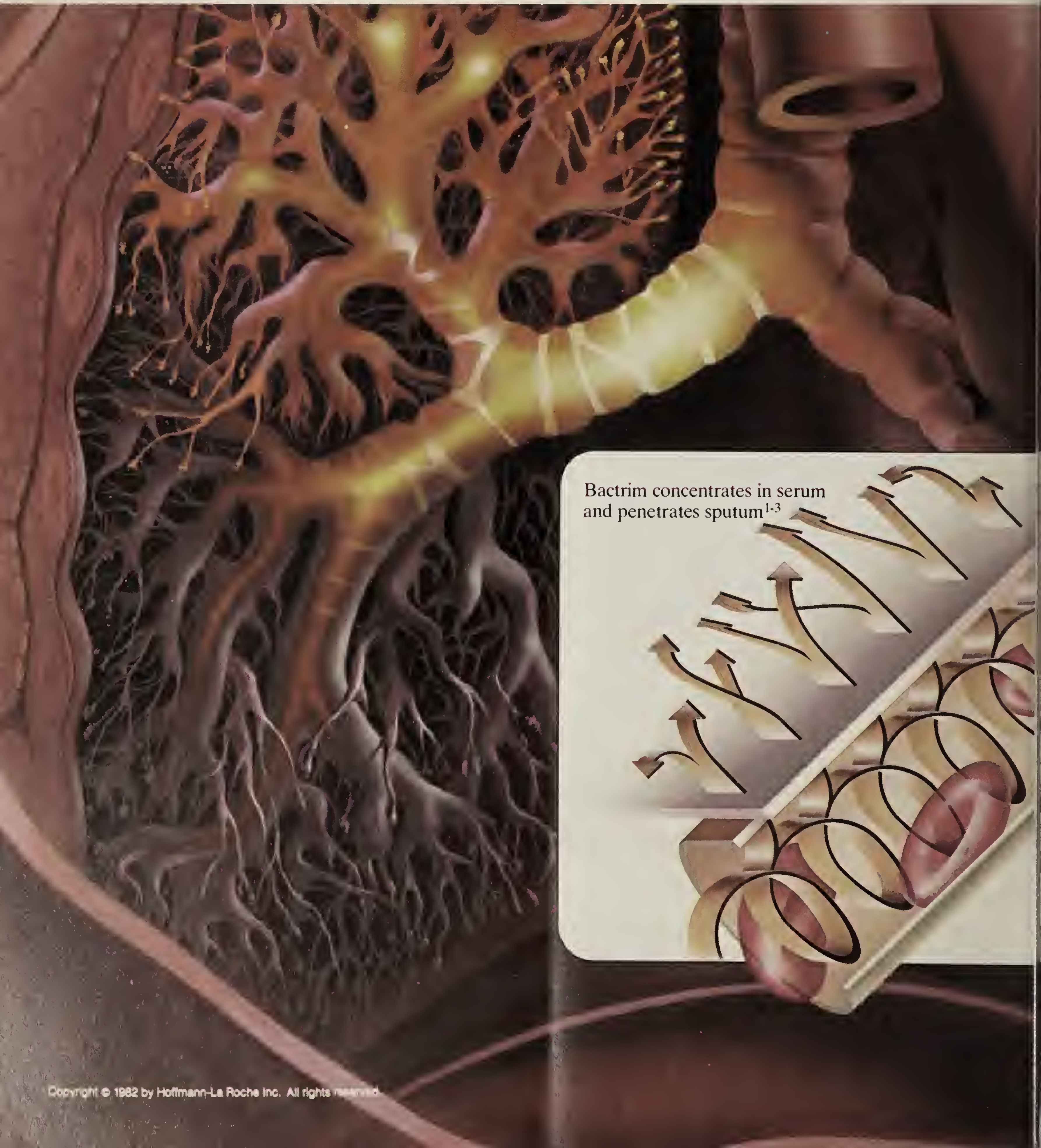
for the varied faces of angina

PROCARDIA®
(NIFEDIPINE) *Capsules 10 mg*

[*] Procardia is indicated for the management of:
1) Confirmed vasospastic angina.
2) Angina where the clinical presentation suggests a possible vasospastic component.
3) Chronic stable angina without evidence of vasospasm in patients who remain symptomatic despite adequate doses of beta blockers and/or nitrates or who cannot tolerate these agents. In chronic stable angina (effort-associated angina) PROCARDIA has been effective in controlled trials of up to eight weeks' duration in reducing angina frequency and increasing exercise tolerance, but confirmation of sustained effectiveness and evaluation of long-term safety in these patients are incomplete.

Please see PROCARDIA *brief summary on adjoining page*

Bactrim™ attacks the
(trimethoprim and sulfamethoxazole/Roche)
in acute exacerbations



Bactrim concentrates in serum and penetrates sputum[1-3]

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ROCHE

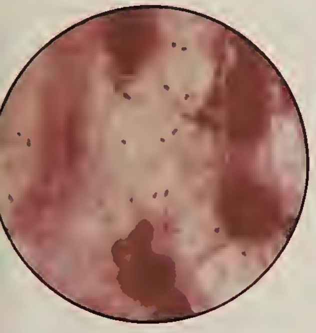
najor pathogens
f chronic bronchitis*

Bactrim clears sputum of susceptible bacteria

In sputum cultures from patients with acute exacerbations of chronic bronchitis, *H. influenzae* and *S. pneumoniae* are isolated more often than any other pathogens.[4,5] One study of transtracheal aspirates from 76 patients with acute exacerbations found that 80% of the isolates were of these two pathogens.[5]

Bactrim is effective *in vitro* against most strains of both *S. pneumoniae* and *H. influenzae*—even ampicillin-resistant strains. And in acute exacerbations of chronic bronchitis involving these two pathogens, sputum cultures taken seven days after a two-week course of therapy showed that Bactrim eradicated these bacteria in 91% (50 of 55) of the patients treated.[6]

acks *H. influenzae*—even
mpicillin-resistant strains



attacks *S. pneumoniae*

Bactrim reduces coughing and sputum production

In three double-blind comparisons with ampicillin *q.i.d.*, Bactrim DS proved equally effective on all clinical parameters.[7-9] Bactrim reduced the frequency and severity of coughing, reduced the amount of sputum produced and cleared the sputum of purulence.

Bactrim has the added advantages of *b.i.d.* dosage convenience and a lower incidence of diarrhea than with ampicillin, and it is useful in patients allergic to penicillins.

Bactrim also proved more effective than tetracyclines in 10 clinical trials involving nearly 700 patients.[10] Overall clinical condition of the patients, changes in sputum purulence, reduction in sputum volume and microbiological clearance of pathogens—all improved more with Bactrim therapy than with tetracyclines. G.I. side effects occurred in only 7% of patients treated with Bactrim compared with 12% of tetracycline-treated patients. (See Adverse Reactions in summary of product information on next page.)

Bactrim is contraindicated in pregnancy at term and nursing mothers, infants under two months of age, documented megaloblastic anemia due to folate deficiency and hypersensitivity.

Bactrim DS. For acute exacerbations of chronic bronchitis in adults* when it offers an advantage over single-agent antibacterials.

References: 1. Hughes DTD, Bye A, Hodder P: *Adv Antimicrob Antineoplastic Chemother I/2*:1105-1106, 1971. **2.** Jordan GW *et al: Can Med Assoc J 112*:91S-95S, Jun 14, 1975. **3.** Beck H, Pechere JC: *Prog Antimicrob Anticancer Chemother 1*:663-667, 1969. **4.** Quintiliani R: Microbiological and therapeutic considerations in exacerbations of chronic bronchitis, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts;* Princeton Junction, NJ, Communications Media for Education, Inc., 1980, pp. 9-12. **5.** Schreiner A *et al: Infection 6*(2):54-56, 1978. **6.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **7.** Chodosh S: Treatment of acute exacerbations of chronic bronchitis: results of a double-blind crossover clinical trial, in *Chronic Bronchitis and Its Acute Exacerbations: Current Diagnostic and Therapeutic Concepts. Op. cit.*, pp. 15-16. **8.** Chervinsky P: Double-blind clinical comparisons between trimethoprim-sulfamethoxazole (Bactrim™) and ampicillin in the treatment of bronchitic exacerbations. *Ibid.*, pp. 17-18. **9.** Dulfano MJ: Trimethoprim-sulfamethoxazole vs. ampicillin in the treatment of exacerbations of chronic bronchitis. *Ibid.*, pp. 19-20. **10.** Medici TC: Trimethoprim-sulfamethoxazole (Bactrim™) in treating acute exacerbations of chronic bronchitis: summary of European clinical experience. *Ibid.*, pp. 13-14.

Economical
b.i.d.

Bactrim™ DS

(160 mg trimethoprim and 800 mg sulfamethoxazole/Roche)

*Due to susceptible organisms. **Please see next page for summary of product information.**

Bactrim™

(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides, patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients.

Pregnancy: Teratogenic Effects. Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: Not recommended for infants less than two months of age.

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

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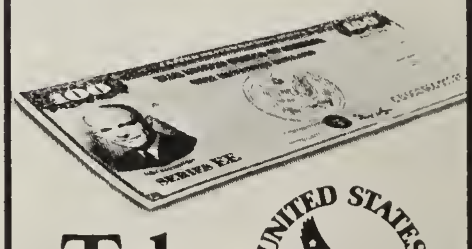

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U-M reorganizes

A new position, **"vice provost for medical affairs,"** with responsibility for the Medical Center, has been established at the University of Michigan. Both the dean of the medical school and the executive director of the U-M Hospitals will report to the vice provost.

The new position provides a single node of responsibility for the hospitals and medical school, while maintaining the medical school within the overall academic structure of the University.

The vice provost will be responsible for "the planning, coordination and administration of the Medical Center; cooperative problem-solving between the hospitals and the medical school on a variety of medical care issues relating to the mission of the medical school; overseeing the programmatic and logistical development of the replacement hospital project; monitoring and highlighting for the executive officers' and the regents' emerging policy issues in the medical care and medical education arena."

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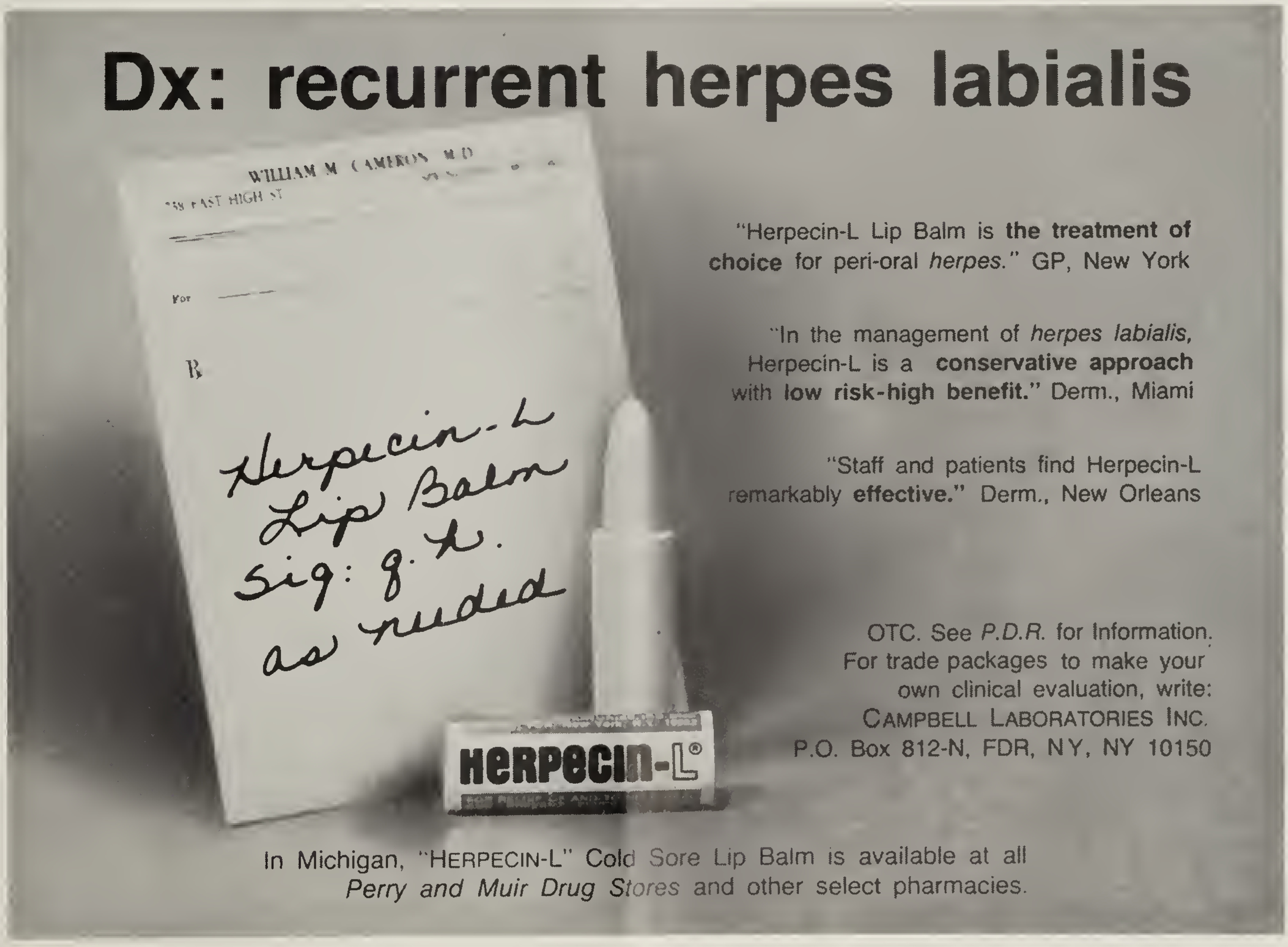

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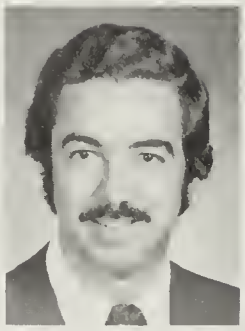
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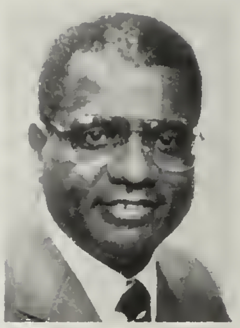
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MSMS members are encouraged to submit news items about themselves and their colleagues to *Michigan Medicine*, 120 W. Saginaw, East Lansing 48823. Appropriate items will appear in this column in the next available issue.

COORDINATOR OF BURN SERVICE

Hurley Medical Center, a 573-bed teaching medical center with University affiliation in Flint, Michigan, is recruiting a quarter-time Physician as Coordinator of its Burn Program.

The successful applicant will have responsibility for the administrative aspects of the program and coordination of the overall burn care delivery including Emergency Room, Operating Room, Recovery Room, and the Burn Unit. The individual will participate in the education of residents, nurses and other health care professionals, and the community at large. In addition, the individual will represent the Burn Program for the Department of Surgery and will be responsible for maintaining the program at a high level of excellence.

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New member of the 10-physician AMA Steering Committee to implement its new Hospital Medical Staff Section is **Henry M. Domzalski, MD,** Detroit. . . . **G. Richard Keskey, MD,** Escanaba, was elected to serve a three-year term on the board of directors of Medical Eye Services of Michigan, Inc. The non-profit organization advises Michigan Ophthalmologists and Opticians. . . . **Gary Ruoff, MD,** Kalamazoo, recently was appointed to the Commission on Education, and **Charles Zimont, MD,** Constantine, to the Commission on Public Health for the American Academy of Family Physicians. . . . Former Michigan Department of Public Health Director, **Bailus Walker, Jr., PhD, MPH,** is a graduate professor of occupational and environmental health sciences at the School of Human Ecology at Howard University in Washington, DC. . . . **H. Saul Sugar, MD,** Southfield, nationally known glaucoma expert, is associated with the Department of Ophthalmology at Henry Ford Hospital. Doctor Sugar authored the first modern book on glaucoma. . . . **James H. Thrall, MD,** has succeeded **William R. Eyler, MD,** as chairman of the Henry Ford Hospital Department of diagnostic radiology. Doctor Eyler had been chairman since 1955. . . . **Robert J. Priest, MD,** former head of gastroenterology at HFH, was recently honored when the gastroenterology library there was dedicated in his name. He has been with the hospital since 1951. . . . New president-elect of the Detroit Metropolitan Pediatric Society is **Ratnakar Kini, MD,** Detroit. . . . **Roy Bergman, MD,** Escanaba, has been selected as a team physician for the 1984 US Summer Olympic Games by the United States Olympic Committee/Sports Medicine Council. . . . New board member of the Michigan Physicians Mutual Liability Company is **Jay K. Harness, MD,** Chelsea. He also has been named a board member to the Physicians Review Organization of Michigan. . . . University of Michigan Emeritus Prof. **Karl D. Malcolm, MD,** has been named president of the Men's Thursday Luncheon Club of Ann Arbor. . . . . **Louis D. Rickman, MD,** Mount Clemens, was honored by that community as recipient of the Brotherhood/Sisterhood Award. He was cited for his long and dedicated service to Mount Clemens, which included 23 years as school board member, deputy medical examiner, and volunteer at youth homes, church and YMCA.

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CATEGORY I COURSES

***Michigan Medicine* each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517)337-1351.

Date: May 16-20, Advances in Internal Medicine, 11th Annual Spring Update. Location: Towsley Center, Ann Arbor. **Sponsor:** The University of Michigan Medical School, Office of CME, Department of Postgraduate Medicine and Health Professions Education and the Department of Internal Medicine. **Cost:** $475-physician course fee; $295 for physicians-in-training, retired physicians and other health care professionals. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109 (313) 763-1400. **Approved for:** 35 hours of Category I Credit.

Date: May 18, Inflammatory Bowel Disease. Location: Saint John Hospital, 22101 Moross Rd., Detroit 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Surgery. **Cost:** Physicians $90; Residents, fellows, nurses, allied health professionals, and others $35. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education, (313) 343-4877. **Approved for:** 8 hours of Category I Credit.

Date: May 19, 26th Annual Clinic Day: Gastroenterology Update. Location: Children's Hospital of Michigan, Detroit. **Sponsor:** CME Department, Children's Hospital. **Contact:** Continuing Education Dept., Children's Hospital of Michigan, 3901 Beaubien Blvd., Detroit, 48201 (313) 494-5455.

Date: May 20, 13th Annual Cardiology Symposium. Location: Borgess Medical Center. **Sponsors:** Southwestern Michigan Area Health Education Center, and Borgess Medical Center. **Cost:** $85. **Contact:** Charles L. Zeller, Jr., MD, Director, Continuing Medical Education, SMAHEC, 1521 Gull Road, Kalamazoo 49001, (616) 388-7877. **Approved for:** 7 hours of Category I Credit.

Date: May 23, Orthopaedic Clinic Day — 1983. Location: Children's Hospital of Michigan, Detroit. **Sponsor:** CME Dept., Children's Hospital, **Contact:** Continuing Education Dept., Children's Hospital of Michigan, 3901 Beaubien Blvd., Detroit, 48201 (313) 494-5455.

Date: May 23-25, Clinical Chemistry and Immunology 5th Annual Spring Conference. **Location:** The Towsley Center, Ann Arbor. **Sponsor:** U-M Medical School, The Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, and The Department of Pathology. **Cost:** $245. **Contact:** Office of Continuing Medical Education, The Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 18.5 hours of Category I Credit.

Date: May 23-27, Head and Neck Oncology. Location: U-M Towsley Center, Ann Arbor. **Sponsor:** University of Michigan Medical School, The Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, and The Department of Otolaryngology — Head and Neck Surgery. **Cost:** $750. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 43 hours of Category I Credit.

Continued on page 340

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Date: May 26-27, Spring Surgical Symposium: Update in Endocrine Surgery. Location: Towsley Center, Ann Arbor. **Sponsor:** Office of CME, Department of Postgraduate Medicine and Health Professions Education and The Division of Endocrine Surgery, Section of General Surgery, Department of Surgery, University of Michigan. **For:** Endocrinologists, general surgeons, internists and other health care professionals. **Cost:** $355 - physician course fee; $265 - physician-in-training and other health care professional fee. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 11 hours of Category I Credit.

Date: June 1-3, Current Topics in Blood Banking: 10th Annual Symposium. Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Medical School, Office of CME, Department of Postgraduate Medicine and Health Professions Education and the Department of Pathology. **Cost:** $195-physician course fee, $130- physician-in-training, retired physicians or other health care professionals. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 12.5 hours of Category I Credit.

Date: June 6-7, Current Concepts in Clinical Microbiology Location: Towsley Center, Ann Arbor. **Sponsor:** U-M Medical School, Office of CME, Department of Postgraduate Medicine and Health Professions Education and Clinical Microbiology Laboratory Department of Pathology. **Cost:** $195-physician course fee; $135-other health care professionals. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor, 48109. **Approved for:** 13 hours of Category I Credit.

Date: June 13-14, Evaluating Child Abuse and Neglect: The Difficult Diagnosis. Location: Towsley Center, Ann Arbor. **Sponsor:** Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, U-M. **For:** Pediatricians, family and general practitioners, emergency physicians, psychiatrists and other health care professionals. **Cost:** $175 — physician course fee; $135 - physician-in-training and other health professionals fee. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 14 hours of Category I Credit.

Date: June 13-17, Basic Principles of Manual Medicine. Location: Kellogg Center for Continuing Medicine, MSU, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine, Human Medicine and North American Academy of Manipulative Medicine. **Contact:** Sandy Kilbourn, A329 E. Fee, MSU-COM, East Lansing 48823 (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: June 15, Geriatrics and Family Practice, Medical and Ethical Decision Making. Location: Saint John Hospital, 22101 Moross Rd., Detroit 48236. **Sponsor:** Saint John Hospital, Continuing Medical Education. **For:** Family Practice. **Cost:** Physicians $90; Residents, fellows, nurses, allied health professionals, and others $35. **Contact:** Linda Campbell, Program Coordinator, Continuing Medical Education, (313) 343-3877. **Approved for:** 8 hours of Category I Credit.

Date: June 16, First Annual Research Day/Paper Competition. Location: Kalamazoo. **Sponsor:** Southwestern Michigan Area Health Education Center. **For:** All attending physicians, residents and medical students in the Kalamazoo medical community only. **Contact:** Judith B. Willis, MA, PA-C, Director, Research & Regional Medical Education, SMAHEC, 616-383-6360 or 383-7363. **Approved for:** 4 hours of Category I Credit.

Date: June 16-17, Clinical Laboratory Computers: Symposium 1983. Location: U-M, The Towsley Center, Ann Arbor. **Sponsor:** U-M Medical School, The Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education, and the Department of Pathology. **Cost:** $245. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 12 hours of Category I Credit.

Date: June 16, 17 and 18, Medicolegal Investigation of Death. Location: Hotel Pontchartrain, Detroit. **Sponsor:** Wayne State University School of Medicine, Department of Pathology and Wayne County Medical Examiner's Office. **Contact:** Wayne State University School of Medicine, Division of Continuing Medical Education, 4201 St. Antoine, 4H UHC, Detroit 48201, (313) 577-1180. **For:** Medical examiners, pathologists engaged in medicolegal work, coroners, and other interested individuals. **Approved for:** 19 hours of Category I Credit.

Date: June 16-18, 34th Annual Keyport-Gaylord Trauma Symposium. Location: Hidden Valley Club, Gaylord. **Sponsor:** Michigan Committee on Trauma, ACS; Michigan Society of Critical Care Medicine; WSU School of Medicine. **Cost:** $75. **Contact:** B. E. Henig, MD, PO Box 605, Grayling 49738. **Approved for:** 12 hours of Category I Credit.

Date: June 19-24, Nineteenth Annual Northern Michigan Summer Conference. Location: Hilton Shanty Creek, Bellaire. **Sponsor:** U-M Office of CME, Dept. of Postgraduate Medicine and Health Professions Education. **Cost:** $395. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 20 hours of Category I Credit.

Date: June 21-23, Real-time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Department of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: July 10-13, Intermediate Course on Craniosacral Technique. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: July 13, Second Summer Conference: Dermatology for the Practitioner. Location: Towsley Center, Ann Arbor. **Sponsor:** Office of CME, Department of Postgraduate Medicine and Health Professions Education, U-M. **For:** Family and general practitioners, internists, pediatricians, and other interested health care professionals. **Cost:** $115. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 8 hours of Category I Credit.

Date: July 18-19, Developing, Marketing, and Managing Conferences: Making It In Tough Times. Location: The Towsley Center, Ann Arbor. **Sponsor:** The University of Michigan Medical School, The Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education. **For:** Those who will develop/manage conferences and need to know how to do it more effectively and economically, whether for universities, hospitals, professional societies, businesses, or hotels. **Cost:** $345. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 12.5 hours of Category I Credit.

Date: July 21-22, Clinical Dietitian's Update. Location: Towsley Center, Ann Arbor. **Sponsor:** Office of CME, Department of Postgraduate Medicine and Health Professions Education and U-M Hospitals Nutrition Services, Department of Dietetics. **Cost:** $135. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 13 hours of Category I Credit.

July 28-29, Coller Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City. **Sponsor:** Munson Medical Center. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th & Madison Sts., Traverse City 49684 (616) 947-6140, Ext. 146. **Approved for:** 9 hours of Category I Credit.

Date: August 15-19, Tutorial on Direct Action Thrusting. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: September 12-16, Basic Muscle Energy Tutorial. Location: Kellogg Center (MSU), East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Sept. 29-Oct. 2, Sixth Annual Course in Diagnostic Ultrasound. Location: The Towsley Center, U-M Medical School, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **Contact:** Office of Continuing Medical Education, Towsley Center Box 057, University of Michigan Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 24 hours of Category I Credit.

Date: Sept. 30-Oct. 2, Tutorial on Myofascial Release Technique. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: Oct. 3-7, Advanced Muscle Energy Tutorial (above diaphragm). Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

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MEETINGS

MSMS, MSMS/A, AMA, and medical assistants

May 18 — "Improving Your Practice in Today's Competitive Climate," an MSMS workshop for established physicians, Southfield, Michigan Inn. $55 fee includes lunch, coffee breaks, handouts and "Challenge of the 80's" book. Look for registration forms in *Michigan Medicine* and *Medigram*.

May 20-21 — AMA Conference on Prevention of Disabling Injuries. Omni International Hotel, Miami, contact: AMA, Division of Personal and Public Health Policy, 535 N. Dearborn, Chicago 60610.

May 25 — "Improving Your Practice in Today's Competitive Climate," an MSMS workshop for established physicians, Grand Rapids Marriott Inn. $55 fee includes lunch, coffee breaks, handouts and "Challenge of the 80's" book. Look for registration forms in *Michigan Medicine* and *Medigram*.

May 26-27 — Annual Gull Lake Conference, MSMS Committee on Maternal and Perinatal Health, MSU Conference Center, Gull Lake, Kalamazoo, contact: Katie Brewbaker, MSMS headquarters, 517/337-1351.

June 1 — "Improving Your Practice in Today's Competitive Climate," an MSMS workshop for established physicians, Ann Arbor Holiday Inn, West Bank. $55 fee includes lunch, coffee breaks, handouts and "Challenge of the 80's" book. Look for registration forms in *Michigan Medicine* and *Medigram*.

June 18-23 — Annual Meeting of the AMA House of Delegates, Marriott Hotel, Chicago, contact: Bruce Ambrose, MSMS headquarters.

June 19-22 — AMA Auxiliary Convention, The Drake Hotel, Chicago, IL, contact: Caroline Rich, 517/337-1351.

July 14-15 — AMA 1983 Regional Membership Meeting, Knickerbocker Hotel, Chicago, contact: AMA, 535 N. Dearborn St., Chicago 60610.

July 21-22 — AMA 1983 Regional Membership Meeting, Sir Francis Drake Hotel, San Francisco, contact: AMA, 535 N. Dearborn St., Chicago 60610.

July 21-24 — MSMS Council Midsummer Meeting, Deer Lake, Boyne Mountain, contact: Warren F. Tryloff, MSMS headquarters.

July 28-29 — AMA 1983 Regional Membership Meeting, Ramada Renaissance Hotel, Washington, DC, contact: AMA, 535 N. Dearborn St., Chicago 60610.

Sept. 14 — MSMS Council Meeting (Rescheduled from Sept. 21 to Sept. 14), MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Oct. 27 — MSMS Leadership Conference, Long's Convention Center, Lansing, contact: William Madigan or Kevin Kelly, MSMS headquarters, 517/337-1351.

Nov. 15-17 — MSMS Annual Scientific Meeting, Hyatt Regency, Dearborn, contact: Sherry Fent, MSMS headquarters, 517/337-1351.

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Nov. 23 — MSMS Council, MSMS headquarters, contact: Warren F. Tryloff, MSMS headquarters.

Other Meetings

May 17-19 — Silver Anniversary Seminar, 25th Annual Meeting of The Michigan Society for Respiratory Therapy, Hyatt Regency Flint, contact MSRT Program Registration, PO Box 950, 120 W. Saginaw St., East Lansing 48823.

May 19-21 — 1983 Annual Meeting, Michigan Association of Osteopathic Physicians and Surgeons, Inc., Dearborn, contact: D. A. "Tony" Deshaw, 33100 Freedom Rd., PO Box 286, Farmington, 48024, (313) 476-2800.

May 21 — Physicians of India Association, Michigan, Annual Dinner and Entertainment Evening, Troy Hilton, contact: I. Galaria, Treasurer, 5231 Provincial Dr., Bloomfield Hills 48013.

May 23 — Alzheimer's Disease and Related Disorders Association, public information meeting, Clinical Center, Michigan State University, contact: ADRDA, Tri-County Support Group, (517) 485-6240.

May 26 — Southwestern Michigan Perinatal Association "Perinatal Potpourri," Western Michigan University, Kalamazoo, contact: Karen Riley, RN, OB Education Coordinator, Memorial Hospital, 2611 Morton Ave., St. Joseph 49085, 616/983-8171.

May 26-31 — American Association for the Advancement of Science, Westin Hotel, Detroit, contact: Ms. Elisabeth Zeutschel, 1101 Vermont Ave. NW, Washington, DC 20005, (202) 842-9530.

June 4-7 — 1983 Annual Meeting, Michigan Optometric Association, Boyne Highlands Inn, Harbor Springs, contact: William D. Dansby, Fifth Floor Capitol Bldg., 115 W. Allegan St., Lansing, 48933, (517) 482-0616.

June 5-9 — 1983 Annual Meeting, American Society of Hospital Pharmacists, Cobo Hall, Detroit, contact: Marilyn Sullivan, 4630 Montgomery Ave., Bethesda, MD 20814 (301) 657-3000.

June 22-24 — 1983 Annual Meeting, Michigan Licensed Practical Nurses Association, Amway Grand Plaza, Grand Rapids, contact: Barbara Wells, 5900 Executive Dr., Lansing, 48910, (517) 882-6657.

June 23-25 — 1983 Upper Peninsula Medical Society Educational Meeting, Iron Mountain, contact: UP Medical Society, DCMH, Woodward Avenue, Iron Mountain 49801.

June 24 — Annual Meeting, Upper Peninsula Medical Society, Iron Mountain, contact: Donald J. Jacobs, MD, 1609 Parkview Drive, Iron Mountain 49801.

June 30 — Michigan Hospital Association Annual Meeting, Mackinac Island, contact: MHA, 6215 W. St. Joseph Highway, Lansing 48917 (517) 323-3443.

August 7-11 — 1983 Annual Meeting, National Pharmaceutical Association, Westin Hotel, Detroit, contact: James N. Tyson, PO Box 934, Howard University, Washington, DC 20059, (202) 636-7963.

August 19-21 — 1983 Congress, Michigan Association of the Professions, Sugar Loaf Mountain Resort, Cedar, contact MAP, 1407 S. Harrison Road, Suite 350, East Lansing 48823.

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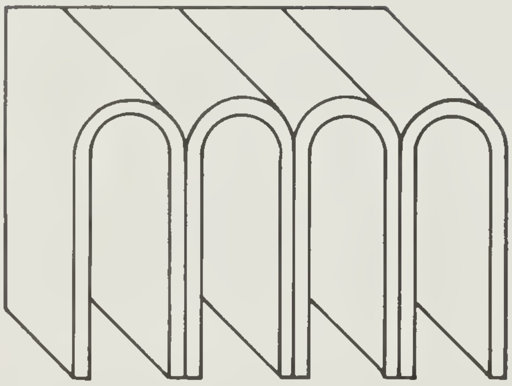

Lowell B. Ashley, MD
Fort Lauderdale, Florida

Lowell B. Ashley, MD, former chief of surgery of Detroit's Harper Hospital, died February 19. He was 90. Doctor Ashley earned his medical degree from Wayne State University in 1914, then served as chief of surgery for the 17th General Hospital in Africa and in Italy during World War II. He was a retired US Army colonel, a member of the American College of Surgeons, the American Board of Surgery, and past president of the Academy of Surgery of Detroit.

Alexander S.Z. Budd, MD
Bloomfield Hills

Alexander S.Z. Budd, MD, Bloomfield Hills, died February 27 at the age of 83. Doctor Budd graduated from the Detroit College of Medicine and Surgery in 1933. He served as a medical officer in the US military from 1942 until 1945. A general practitioner, Doctor Budd was affiliated with Holy Cross Hospital in Detroit, and would have received an MSMS 50-year pin for long and dedicated medical practice at this year's House of Delegates meeting in Detroit.

Donald Hadesman, MD
Bloomfield Hills

Donald Hadesman, MD, Bloomfield Hills internist, died March 5. He was 57. Doctor Hadesman, chief of medicine at Lake Shore Medical Center in Detroit for 27 years, earned his MD in 1951 from the University of Illinois. He was a member of the American College of Physicians and the American College of Chest Physicians, and was active in the Michigan Heart Association and the American Geriatrics Society. Doctor Hadesman was a veteran of the US Army Medical Corps.

Edward F. Kronschnabel, MD
Marquette

Edward F. Kronschnabel, MD, Marquette, died February 8 at the age of 61. He earned his MD at Marquette University in 1951. Doctor Kronschnabel was an otolaryngologist, and had been affiliated with St. Lukes and St. Mary's hospitals of Marquette, and Bell Memorial Hospital in Ishpeming. He was a member of the Milwaukee Oto-Ophthalmology Society and the Wisconsin-Upper Michigan Society for Ophthalmology and Otology.

Leonard S. Linkner, MD
Huntington Woods

Leonard S. Linkner, MD, Huntington Woods internist, died February 15 at the age of 65. Doctor Linkner, founder of the B'nai B'rith Health Care Unit, graduated from the University of Michigan Medical School in 1943. He was on staff at Harper-Grace, Sinai, and Crittendon hospitals, and maintained a practice in Southfield. A member of the American College of Physicians and the American Society of Internists, Doctor Linkner was a veteran of the US Army Medical Corps.

Earl G. Merritt, MD
Grosse Pointe

Earl G. Merritt, MD, Grosse Pointe, died February 16. He was 82. He earned his MD at the University of Toronto in 1922, then joined the staff of Harper Hospital. This hospital affiliation spanned 60 years. Doctor Merritt devoted more than 20 years of his medical career as chief of the medical

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MEETINGS/*Continued*

August 21-25 — Pharmacy 100 — Anniversary Convention Celebration, Michigan Pharmacist Association, contact: MPA Educational Center, 815 N. Washington Ave., Lansing 48906.

Sept. 6-10 — Association for the Advancement of Medical Instrumentation (AAMI) 1983 Regional Meeting, Detroit, interested participants/cosponsors for 1983 or 1984 meetings should contact: Renee Pietrangelo, AAMI national office, 703/525-4890.

Oct. 6-9 — 1983 Annual Meeting, National Black Nurses Association, Westin Hotel, Detroit, contact: E. Lorraine Baugh, PO Box 18358, Boston, MA 02118, (617) 266-9703.

Oct. 10-14 — 1983 Annual Meeting, National Mental Health Association, Hyatt Regency Dearborn, contact: Molly Mannon, 1800 N. Kent St., Arlington, VA 22209, (703) 528-6405.

November 9-13 — American Medical Women's Association Annual Meeting, Hyatt Regency, Dearborn, contact: Meeting Coordinator, AMWA National Office, 465 Grand Street, New York, NY 10002.

Nov. 10-12 — Michigan Association for Health, Physical Education, Recreation & Dance, Hilton Inn, Traverse City, contact: Sanford Dornbos, Eastern Michigan University, Ypsilanti, 48197, (313) 487-0175.

Nov. 11 — 1983 Annual Meeting, American Medical Women's Association, Dearborn, contact: Carol Meyers, 465 Grand St., New York, NY 10002, (212) 533-5104.

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department at Detroit Edison, and maintained a private surgical practice through 1982. He was past president of the Detroit Academy of Surgery and of Detroit Roundtable International, and was an avid boater.

Arthur Z. Ostrowski, MD
Detroit

Arthur Z. Ostrowski, MD, lifelong Detroit resident, died March 6 at the age of 55. Doctor Ostrowski, chief of neurosurgery at Mt. Carmel Mercy Hospital since 1973, earned his MD in 1952 at St. Louis University School of Medicine. He had been on staff at Providence Hospital, and was a consultant at Oakwood, Detroit General, Allen Park V.A., and Receiving hospitals. Doctor Ostrowski was a junior clinical instructor of neurosurgery at University Hospital in Ann Arbor, and an instructor of neuroanatomy and clinical assistant professor at Wayne State University. He also taught at Mercy Hospital. A member of the Detroit Surgical Society, the American Association of Neurological Surgeons, and the Congress of Neurological Surgery, Doctor Ostrowski had been on the Medical Executive Committee at Mt. Carmel Mercy Hospital.

L. Paul Ralph, MD
Sun City, Arizona

L. Paul Ralph, MD, former chief of staff at Butterworth Hospital in Grand Rapids, died March 13. He was 80. Doctor Ralph graduated from Jefferson Medical College in Pennsylvania in 1927, then went on to become an internist specializing in cardiology. He did extensive postgraduate work at Harvard and New York Postgraduate Schools of Medicine. Doctor Ralph was past president of Kent County Medical Society, the Kent Medical Foundation and the Michigan Heart Association. He retired in 1973 after more than 40 years of practice in Grand Rapids.

George M. Wilson, MD
Marquette

George M. Wilson, MD, Marquette, died February 26 at the age of 58. Doctor Wilson, MSMS delegate, Judicial Commission member and alternate delegate to the AMA, earned his MD in 1948 from the University of Syracuse School of Medicine. He was an associate professor of medicine at Michigan State University College of Human Medicine and coordinator of internal medicine instruction for the UP Medical Education program. He was named "Teacher of the Year" of that program in 1982. Doctor Wilson was a fellow of the American College of Physicians, a trustee of the Michigan chapter of the Arthritis Foundation, president of Combined Health Services of Marquette, and on the boards of directors of Blue Cross Blue Shield of Michigan and the UP Quality Assurance Association.

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1866

PRESIDENT'S PAGE

The goal: to advance the art of medicine

By James H. Tisdel, MD
Port Huron

With this column, Doctor Tisdel completes his year of association with *Michigan Medicine* as president of the Michigan State Medical Society. Incoming President Donald K. Crandall, MD, will begin his regular columns with the next issue.

This is the final chapter of a year of president's pages and several years of opinion columns in *Michigan Medicine.* I have received much comment from the membership, most in approval, but some in disagreement. I have discussed insurance, the FTC, cost containment and recently the advent of competition in the practice of medicine, just to mention a few. In this past year during my presidency I have tried to advance my fellow physicians' thinking about the art of medicine, practice based on empathy and the Golden Rule.

One of the more interesting and thought-provoking comments I received in this past year was in response to the advent of competition in medical practice. From that comment I found it very reassuring that competition for money is not primary with many in our profession. Not everyone works for money. There are those who studied medicine for the satisfaction of growing and spreading understanding, some who did it to satisfy burning curiosity, and some who had other motives more worthy than competition for money. Many studied medicine with the spirit of desire to help others.

The whole mind-set of our leaders, thinkers and doers in relation to money and the marketplace and the economy is a genocidal fantasy, commented this physician. We in America and the whole world are rushing to the brink of catastrophe because of the kind of competitiveness based on money.

So let's acknowledge the other side. The need to relate and communicate to affirm and be reaffirmed also is there. The need to be a meaningful part of something that has value and survives is strong. Man searches for meaning and needs to hope.

So down with competitiveness! Let's talk about cooperation and problem-solving, and the application of ethics and doing what we were put here for.

These are comments I feel are worth repeating and repeating as we seek solutions to medicine's problems. In the president's page this month I am proud to share with all other doctors the view of this particular member about competition and the ideals medicine should stand for — the other side.

I must also then leave with you my thoughts on what we must stand for steadfastly and without compromise. The physician is, and must continue to be, the advocate of our patients and their right to quality care. All the plans from government and third-party payors seek cost containment, and this must be a consideration. But I have yet to read about their concern for the quality of care to be delivered. We must not allow quality to be sacrificed on the altar of cost. And while we are at it, we must maintain a single quality available to all regardless of their station in life.

Medicine must be an advocate of quality and equality in treatment for all. Our legislators, our leaders, our bureaucrats in Lansing and Washington must begin to think of the quality of the product they purchase for those most in need, and third party payors must likewise think in terms of quality, what they will get for the premium dollars they spend.

This year also has seen the settlement of our case with the FTC. In spite of the coverage given in the newspapers, I agree with our legal staff and our counselors, that MSMS was justified in appealing the law judge's findings. The full commission has delivered us a ruling that we can abide by and still represent our members to the same degree as before.

So we come to the close of a year of my service to you as MSMS president. I have worked hard to personally see as many members as possible, and to present a caring, informed physician-leader to the public.

I hope I will be judged successful in these campaigns. I can tell you it has been a rewarding, busy year for me and I have been deeply honored to serve as your official spokesman.

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References: **1.** Kales A *et al: J Clin Pharmacol 17*:207-213, Apr 1977 and data on file, Hoffmann-La Roche Inc., Nutley, NJ. **2.** Kales A: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **3.** Zimmerman AM: *Curr Ther Res 13*:18-22, Jan 1971. **4.** Kales A *et al: JAMA 241*:1692-1695, Apr 20, 1979. **5.** Kales A, Scharf MB, Kales JD: *Science 201*:1039-1041, Sep 15, 1978. **6.** Kales A *et al: Clin Pharmacol Ther 19*:576-583, May 1976. **7.** Kales A, Kales JD: *Pharmacol Physicians 4*:1-6, Sep 1970. **8.** Frost JD Jr, DeLucchi MR: *J Am Geriatr Soc 27*:541-546, Dec 1979. **9.** Dement WC *et al: Behav Med 5*:25-31, Oct 1978. **10.** Vogel GW: Data on file, Hoffmann-La Roche Inc., Nutley, NJ. **11.** Karacan I, Williams RL, Smith JR: The sleep laboratory in the investigation of sleep and sleep disturbances. Scientific exhibit at the 124th annual meeting of the American Psychiatric Association, Washington, DC, May 3-7, 1971. **12.** Pollak CP, McGregor PA, Weitzman ED: The effects of flurazepam on daytime sleep after acute sleep-wake cycle reversal. Presented at the 15th annual meeting of the Association for Psychophysiological Study of Sleep, Edinburgh, Scotland, June 30-July 4, 1975. **13.** Data on file, Hoffmann-La Roche Inc., Nutley, NJ.

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Vol. 82, No. 25 May 19, 1983

Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

OB/GYNs TO DISCUSS PRENATAL RHOGAM USE

Prenatal use of Rhogam, medical and surgical intervention during pregnancy, grant support in obstetrics/gynecology, current medical legislation and economic issues are the topics for the annual MSMS Gull Lake Conference. The meeting is May 26-27 at the MSU Gull Lake Conference Center, Hickory Corners. Details are available from Katie Brewbaker at MSMS headquarters.

DOCTOR CRANDALL TESTIFIES MAY 16 TO WHY COSTS RISE

Most cost containment efforts he has seen to date might more aptly be described as "a reduction in payment with the expectation of the same level of services." So testified MSMS President Donald K. Crandall, MD, Muskegon, May 16 before the House Special Ad Hoc Committee on Health Care Cost Containment. The ad hoc committee invited MSMS and other interested organizations to make recommendations for containing health care costs. Doctor Crandall outlined the major external, internal and government factors driving up the price and demand for medical services, and described major MSMS activities to contain health care costs. He divided MSMS efforts into areas of physician education, peer review, professional liability and the Physician Primary Sponsor Plan. "MSMS hopes this ad hoc committee can grapple with some of the very tough social and political issues which need to be addressed if a true reduction in health care costs can be achieved," said Doctor Crandall, who offered further MSMS assistance. Also testifying before the committee was Richard Horsch, MD, for the Wayne County Medical Society.

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MSMS TELLS HOW TO AVOID NEW CRISIS IN MEDICAL LIABILITY

The soaring numbers of medical malpractice cases and the high settlements being awarded may drive Michigan into another professional liability crisis. Right now, these conditions are contributing to the high costs of delivering medical care in the state. That is the message of the new MSMS booklet, "Avoiding a New Crisis in Medical Professional Liability." It was produced in March to coincide with the introduction of the omnibus medical liability bill, SB 224, which seeks to alleviate the deteriorating medico-legal situation. The bill, introduced by Sen. Patrick McCollough (D-Dearborn), is in the Senate Judiciary Committee. The MSMS booklet has been distributed to all legislators, to MSMS delegates and alternates, to county and specialty medical societies, to Michigan's AMA delegates and to key offices at the AMA. Interested members may obtain a copy by writing Mert Scholten at MSMS headquarters.

1983 MAP'S 25th YEAR

The Michigan Association of the Professions marks its 25th anniversary in 1983. Founded in 1958 by Hugh W. Brenneman and the MSMS leadership, it was the first organization of its kind in the U.S. MAP now represents 13 professional organizations. Under new executive director Paxton Riddle, MAP plans to take an aggressive role in the legislative area through its Government Affairs Council.

RECENT LEGAL ACTIONS AFFECT MICHIGAN MDs

Two recent Court of Appeals decisions have important ramifications for the practice of medicine.

These include the ruling that chiropractors no longer can give general physical exams, use ultrasound and other similar treatment modalities, or dispense vitamins. The appeals court upheld a 1977 Ingham County Circuit Court ruling, taking issue with the propriety of the chiropractor performing specific tasks allowed for physicians under the Public Health Code. It noted that while the procedures were not harmful, there was a danger that a patient may assume he had been examined thoroughly and had a clean bill of health.

The second important decision is the appeals court's reinstatement of the 1978 Lobbying Act. In 1981 an Ingham County Circuit Court judge declared the act unconstitutional, but the secretary of state and attorney general appealed that decision. All but one provision of the act (that one would have required lobbying organizations to make public their memberships) were upheld by the appeals court. MSMS and a coalition called the Committee for the First Amendment supported the argument that the act is unconstitutional. The committee met May 16 to decide on further strategy. One avenue of action is an appeal to the Supreme Court. Another is to seek new legislation.

CAPSULES

MSMS members who have not remitted their 1983 dues face imminent loss of their membership status and group health care benefits. Those who are delinquent should contact Wayne Burmeister at MSMS headquarters immediately. . . . The subscription rate for Michigan Medicine and Medigram is going up to $30 as of June 1. The increase, which is needed to cover higher costs resulting from the weekly Medigram schedule, was approved by the MSMS Council. Life and retired members' subscription price will increase from $15 to $20 yearly. . . . Michigan Board of Medicine President Donald Kuiper, MD, is quoted in a May 13 American Medical News article. The article discusses the board's difficulties in trying to approve foreign medical schools before licensing their graduates. . . . MSMS, in its continuing efforts to foster adult seat belt use, is joining with the National Safety Council and Michigan McDonalds restaurant owners to print and distribute 20,000 promotional placemats over the Memorial Day weekend.

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Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

MSMS TO TESTIFY AT JUNE 3 HEARING ON LIABILITY BILL

MSMS President-elect Louis R. Zako, MD, Dearborn Heights family physician, will testify June 3 in Lansing at the first hearing on the omnibus medical liability bill. Doctor Zako will describe MSMS support of the bill, SB 224, which is designed to enhance present medical liability laws and help the state avoid a repeat of the 1970's crisis. The bill's five parts would permit consideration of collateral source payments in indemnity hearings, place limits on awards for non-economic losses, allow periodic vs. lump sum damages payments, assure qualifications of expert witnesses and establish degree of fault. The bill, sponsored by Sen. Patrick McCollough and more than 30 of his senate colleagues, is before the Senate Judiciary Committee.

EXCLUSIVE CONTRACTS LEGAL IN MICHIGAN

Michigan hospitals' exclusive contracts with physicians are legal. That recent determination by the Sixth Circuit Court of Appeals in Cincinnati follows a national trend to find such arrangements proper. The Cincinnati ruling was emphasized by MSMS Legal Counsel A. Stewart Kerr and Detroit attorney J. Kay Felt, who spoke at the MSMS Medical Staff Relations Conference May 19 in Lansing. "This would not preclude others from attempting such litigation in state courts," said Mr. Kerr of the contracts ruling. "But this ruling appears to dispose of the matter in the federal courts and is a clear preview of what is likely to happen should a comparable suit be filed in the Michigan state court system." Another speaker at the meeting, Robert Black, MD, chief of staff, Harper-Grace Hospitals, called for better communication between hospital staffs and administrators and more support personnel for chiefs of staff.

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Physicians should pull out their contracts with hospitals and reread them, stressed a speaker at the May 19 seminar on the Tax Equity and Fiscal Responsibility Act (TEFRA). The conference, which was open to the general MSMS membership, was held in Lansing. Physicians at the MSMS Medical Staff Relations Conference earlier that day joined their fellow MSMS members for the TEFRA conference. Doctors should reevaluate their compensation packages with hospitals for inclusion of office space, billing and collections costs, the speaker said. Under the new TEFRA, those items can be excluded, decreasing physicians' reimbursement.

MSMS TESTIFIES AGAINST EXPANDING CHIROPRACTIC SCOPE

It would be bad public policy now to extend the limits on chiropractic, as the current scope of chiropractic practice was forged by citizens, health care professionals and the legislature during the writing of the new Public Health Code. That was the gist of MSMS testimony by Fred E. Patterson, MD, Jackson radiologist, who spoke May 25 before a House subcommittee on health professions and facilities licensing. Doctor Patterson spoke against legislation that would expand chiropractic scope.

MICHIGAN DOCTORS STAR ON TELEVISION

Three mid-Michigan physicians answer viewers' questions every other week as guest experts on the MSMS live, call-in television program, "Housecall." Over 80 telephone calls were received on May 22 Channel 47, WFSL-TV, during the 5:30 to 6 p.m. show. The subject that evening was diet and nutrition. The panelists were Laura Kinzel, dietician; Donald Kuiper, MD, Lansing, and Shirley Robertson-K, MD, Mason. On May 8 the inaugural segment was devoted to fitness and athletic medicine, with physicians John DeBruin, MD; George Kleiber, DO, and Douglas McKeag, MD. Coming up on June 5 are Philip Lange, MD; Sumer Verma, MD, and Clifford Hale, MD, who will answer questions on stress. On June 19 the subject will be cancer, with experts Frank Breen, MD; Robert Peterson, MD, and Mitchell Rinek, MD. The program is carried on many cable networks throughout mid-Michigan. Viewers may call 517/484-7538; medical assistants will take questions and pass them along for possible airing. MSMS Chief of Communications Mert Scholten is program host.

CAPSULES

You have called them councilors, but now you will have to call them directors. That is because the MSMS House of Delegates, at its 1983 annual meeting voted to change the name of the MSMS Council to the MSMS Board of Directors. To ease the transition, *Michigan Medicine* and *Medigram*, along with other official MSMS papers, will use dual designations. . . . Charles C. Vincent, MD, and Anne Mare Ice, MD, are recipients of the Outstanding Physician's and Distinguished Service awards of the Detroit Medical Society. The two were honored May 21 at the DMS Clinic Day 1983 at the St. Regis Hotel, Detroit. . . ."The Economic Effects of the Nuclear Arms Race on Health Services" is the subject of a key talk during the Michigan Public Health Association's annual meeting planned May 31-June 2 at the Park Place Hotel, Traverse City. That will be the topic of David Gold, director of military research, Council on Economic Priorities, New York. . . . The Upper Peninsula Medical Society plans its annual meeting June 23-25 in Iron Mountain. The Dickinson-Iron County Medical Society will host the event. Details are available from John Michael Garrett, MD, Iron Mountain, 906/774-1404.

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Vol. 82, No. 26 May 26, 1983

Vol. 82, No. 27 June 2, 1983
Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

MICHIGAN DELEGATION MAKES FINAL PLANS FOR AMA ANNUAL

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MSMS will greet Michigan medical staff delegates in Chicago prior to the first meeting of the new AMA Medical Staff Section June 16 and 17. The MSMS welcome will provide cohesion and offer guidance in the medical staffs' new role in the AMA. MSMS President Donald K. Crandall, MD, who has been a member of the Michigan delegation for seven years, is planning to be there to share his insights of AMA function and protocol.

The newly-enlarged Michigan delegation planned for the medical staff section activity at its May 25 caucus prior to the 1983 AMA annual meeting June 19-23 in Chicago. The Michigan delegation, which now includes 11 delegates and 11 alternates, will introduce a resolution directed by Michigan doctors serving in the MSMS House of Delegates. The resolution calls for the AMA to reaffirm its 1982 action objecting "to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools." The 1983 resolution also includes the language: "Moreover, it strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities which lack educational resources and experience for supervised teaching of clinical medicine." The resolution will be studied by AMA Reference Committee C on Medical Education.

Candidacy of Doctor Crandall for the AMA Council on Medical Service will occupy most of the delegates' attention. A letterwriting campaign to all members of the AMA House has launched the campaign, backed by plans for Doctor Crandall to visit with each voting member during the annual meeting. . . . Candidates for AMA president-elect are Joseph F. Boyles, MD, Los Angeles, and Charles Max Cole, MD, Dallas; while Frank J. Jirka, MD, of Barrington Hills, Ill., will be installed as president. . . . Richard J. McMurray, MD, Flint, who is chairman of the MSMS delegation, also will act as chairman of the convention Credentials Committee.

MSMS SEEKING NOMINEES TO STATE BOARD

Once again, MSMS is looking for nominees for positions which are opening on the Michigan Board of Medicine. The last time MSMS had the opportunity to nominate physicians to the Board was in 1981. The terms of three board members, including Chairman Donald Kuiper, MD, Lansing, expire this year and they are ineligible for reappointment. The other two are J. C. Breneman, MD, Galesburg, and Carol Pearson, MD, Detroit. A fourth member, whose term is up but who is eligible for reappointment, is Edward Weddon, MD, Stockbridge. The governor makes all appointments to the board. MSMS members interested in serving on the board are urged to contact Kevin Kelly at MSMS headquarters.

STATE HEALTH PLAN GOES TO SHCC

After nearly 80 hours of meetings, the Plan Development Committee of the Statewide Health Coordinating Council has concluded its review of the State Health Plan for 1983-87. The plan now will go before the full SHCC at a special two-day meeting June 16-17. After its approval by the SHCC, the plan is sent to the governor and legislature for approval. MSMS opposed the State Health Plan as originally drafted and is currently reviewing the many amendments made during the committee review process.

The State Health Plan was approved by the Plan Development Committee with a controversial recommendation to raise medical school tuition to create a fund to influence the distribution of physicians. MSMS has opposed this recommendation, which now calls for a tuition increase of at least $2,000 per year, as an unfair tax on the medical student. MSMS delegates adopted a resolution opposing the concept at the 1983 House of Delegates meeting, and will testify against the recommendation at the SHCC meeting June 16-17.

LEGISLATIVE DEVELOPMENTS

The June 3 public hearing on the omnibus medical liability bill (SB 224) has been postponed. MSMS President-elect Louis R. Zako, MD, Dearborn Heights, plans to testify in favor of the bill when the hearing is rescheduled by the Senate Judiciary Committee. The bill is designed to enhance present medical liability laws and to help the state avoid a repeat of the 1970s crisis. . . . Gary Sole, MD, Lapeer ophthalmologist, was to meet in Lansing today with his legislators as part of the Physician Legislative Network. Doctor Sole was to be the guest of Sen. Dan L. DeGrow (R-Port Huron) on the floor of the Senate, and to see Rep. John G. Strand (R-Lapeer). . . . HB 4175, an amendment to the probate code to allow an individual to assign power of attorney to another individual notwithstanding the principal's later disability or incapacity was defeated May 31 by the House of Representatives. The bill had moved to the full House after passing the House Judiciary Committee. It is the latest version of legislation to allow an individual some control over his or her last days despite possible physical and/or mental incapacity at that time. . . . Physicians attending recent MSMS TEFRA workshops already had heard it, and now it is general knowledge that the Health and Human Services secretary has delayed implementation of the Medicare reimbursement regulations until Oct. 2. They were to take effect March 2.

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Vol. 82, No. 28 June 9, 1982
Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

SMS EXPECTS ALL HEARINGS N LIABILITY BILL

MSMS observers believe a hearing on the omnibus medical liability bill, SB 224, is not likely until the fall. The legislature is working to clear up 1983-84 budget details before its summer recess and is not getting into other issues. The bill rests in the Senate Judiciary Committee, which postponed a June 3 hearing when MSMS President-elect Louis R. Zako MD, was scheduled to testify. In the meantime, MSMS is meeting with the State Bar to hammer out differences on the bill, at the urging of sponsor Sen. Patrick McCollough. SB 224, which is strongly supported by MSMS, is designed to enhance existing medical malpractice legislation passed in the mid-70s, and to avert another liability insurance crisis like the one which prompted the original laws.

PSP ENROLLMENTS OUBLE SINCE MARCH

In the past three months, enrollments of Medicaid recipients in the Physician Primary Sponsor Plan in Wayne County have doubled. The total number of persons enrolled as of June 2 was 16,640. Of that figure, 12,826 were enrolled with private physicians, 1,142 with HMOs. The remainder were assigned to the state's Medical Service Administration, as their physician of choice had not yet signed a sponsor contract to become part of the program. (Note: Should a physician treat a Medicaid patient with an MSA designation on his card, the physician may have the patient enrolled with him or her by calling the number on the card.

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With enrollments growing at an increased pace, the PPSP monitoring committee recommended June 2 that the PPSP steering committee ensure that staffing keeps up with enrollments. The plan got off to a slow start, but has greatly increased numbers of participants since March.

ORTHERN MICHIGAN EMINAR JULY 21 N COMPETITION

Inside this issue is the program and sign-up sheet for the next MSMS "Challenge of the 80s" seminar, "Improving Your Practice in Today's Competitive Climate." This seminar is the seventh in a series planned around the state to provide MSMS members with practice management and marketing strategies for today's complex business world. This seminar is scheduled July 21 at the Grand Traverse Village, Acme. The registration fee of $55 includes the MSMS reference manual, "Challenge of the 80s: A Guide to Successful Medical Practice." The manual presents detailed, practical information for the individual physician on managing ethical issues, business practices, the new systems of health care delivery, and communication with colleagues and the public. Contact Mert Scholten at MSMS headquarters for further details.

Note. Interested MSMS members may take advantage at any time of the excellent advice on practice management, finances, patient flow, computers and personnel presented at the MSMS competition seminars. The physician may get more detailed information on an individual basis by contacting John Anthony, general manager, MSMS Physician Service Group, Inc., East Lansing (517/337-1351).

SECOND OPINION PLANS NOW MANDATORY, SAYS BCBSM

Beginning July 1, the Second Surgical Opinion Program for Chrysler and Ford motor company subscribers will be changed. At that time, it will become mandatory for the subscriber to obtain a second opinion on all selected surgical procedures performed on an inpatient basis in a Michigan hospital. Until now, the second opinion route has been optional. If a second opinion has not been secured, the subscriber will be liable for 20 percent of the surgeon's fee for selected procedures.

The elective surgeries subject to second opinions are cataract extraction, cholecystectomy, heart bypass surgery, heart valve surgery, herniorrhaphy, hysterectomy, submucous resection and rhinoplasty, tonsillectomy and adenoidectomy, TUR/prostate surgery, fallopian tube and ovarian surgery. For further information, doctors may call BCBSM numbers 313/225-0700 (Detroit area) or 1/800/832-6789 (all other areas).

BCBSM AMBULATORY SURGICAL PROPOSAL UNDERWAY JULY 1

The new Blue Cross Blue Shield of Michigan ambulatory surgical proposal will begin operating July 1. The ambulatory surgical initiative is designed to encourage physicians and hospitals to use ambulatory settings for surgery whenever feasible without compromising the quality of medical care. The initiative consists of two programs:

1) The least cost setting physician incentive program.
2) The hospital disallowance program.

The physician incentive program will go into effect only for physicians who practice in the following counties: Huron, Livingston, Macomb, Monroe, Oakland, St. Clair, Sanilac, Washtenaw and Wayne. The hospital disincentive program will operate statewide, with the exception of Genesee, Lapeer and Shiawassee counties, where a similar program currently is underway by the Reduce Utilization Now (RUN) Commission.

The physician incentive program will provide incentive payments to physicians who participate either on a formal or on a per case basis for 26 selected procedures when performed in an ambulatory setting. When these selected procedures are performed in the inpatient setting, BCBSM will reduce payments to physicians below current levels unless the inpatient setting is dictated by medical necessity.

Under the hospital disincentive program, BCBSM has selected 80 surgical procedures which in the majority of cases can be performed safely on an ambulatory basis. BCBSM is asking hospital administrative and medical staffs to initiate action to shift these procedures to an ambulatory setting. Over the next six months, BCBSM will monitor those hospitals and physicians responsible for a high percentage of inpatient utilization associted with the 80 procedures. BCBSM has announced it will take corrective action if after this period a high percentage of the procedures continue in the inpatient setting.

"IMPROVING YOUR PRACTICE IN TODAY'S COMPETITIVE CLIMATE"

Because of popular demand and to accommodate MSMS members in northern Michigan, MSMS offers another "Improving Your Practice in Today's Competitive Climate" seminar at the Grand Traverse Village in Acme, Thursday, July 21. Register now to reserve one of the 80 seats available for this meeting.

Reaction to the first six seminars has been outstanding as witnessed by some of these quotes from attendees' evaluations:

> "Exceptional." "Very well organized and interesting." "Excellent seminar; I feel physician staff, especially receptionist, office manager, should attend also." "Overall, this is best seminar of its type I have attended." "Superb! Extremely well organized!"

The Program

8:15- 9:00	Registration
9:00-10:30	"Effective, Efficient Practice Management"
10:40-11:20	"Personnel Pointers for Today"
11:20-12:15	"Computers in Your Practice"
12:30- 1:15	Lunch
1:15- 1:45	"Communications— Key to Patient Satisfaction"
1:45- 2:10	"Meeting Medicine's Challenges"
2:15- 4:30	"Marketing, Maintaining and Building Your Practice"

Please enroll me in the July 21, "Improving Your Practice . . . " Seminar at the Grand Traverse Village, near Traverse City. Enclosed is my check for $55 to cover registration, luncheon, breaks and materials. Cost for non-members is $95. Staff of a member may attend for $75. (Use supplemental sheet to register additional persons or you may copy this form.)

Please make check payable to Michigan State Medical Society.

Name ______________________________ **Specialty** ______________

Address ____

____

(Please return completed form and check to Donna Farougi, MSMS, PO Box 950, East Lansing 48823.)

Registrations will be acknowledged with location map, phone number of site.

COMPLETE LIST OF MSMS COURSES COMING SOON

Appearing in the June 30 Medigram will be the complete list of category I courses scheduled for the 1983 MSMS Annual Scientific Meeting. The meeting is scheduled Nov. 15-17 at the Hyatt Regency Dearborn. Program Chairman David Rovner, MD, East Lansing, and the Annual Scientific Meeting Planning Committee have firmed the list of courses proposed by Michigan medical specialty societies, medical schools and interested individual physicians.

MSMS REACHING OUT TO RESIDENT PHYSICIANS

Members of the MSMS Membership Recruitment and Retention Committee are making arrangements to speak at Michigan hospitals' fall orientation sessions for resident physicians. The goal is to encourage the residents to take an active role in organized medicine. Edward Wojtys, MD, chairman, MSMS Resident Section, is coordinating the effort to reach residents, which is top priority with MSMS during the coming year.

CAPSULES

B. J. Woodley, MD, Trenton urologist, was to observe the regular meeting June 8 of the Michigan Board of Medicine. Doctor Woodley's visit is part of a continuing arrangement made by the MSMS Committee on State Legislation and Regulations to provide MSMS members with a better idea of how the board works. . . . Frank B. Walker II, MD, Detroit, is the new president-elect of the Wayne County Medical Society. Doctor Walker's election will be officially announced at the WCMS annual meeting June 15, when Susan E. Adelman, MD, will be installed as WCMS president. . . . MSMS invites members on a new 12-day air/sea cruise to the Greek Isles Oct. 12-23. The cruise will include three nights in Athens and seven nights aboard a cruise ship with stops including Delphi, Olympia, Sparta, Mykonos and Rhodes. . . . The House Special Ad Hoc Committee on Health Care Cost Containment is investigating the impact of preferred provider organizations and hospital costs on total health care costs. The committee, which meets weekly, is scheduled to examine the significance of medical malpractice soon. An MSMS leader will testify then.

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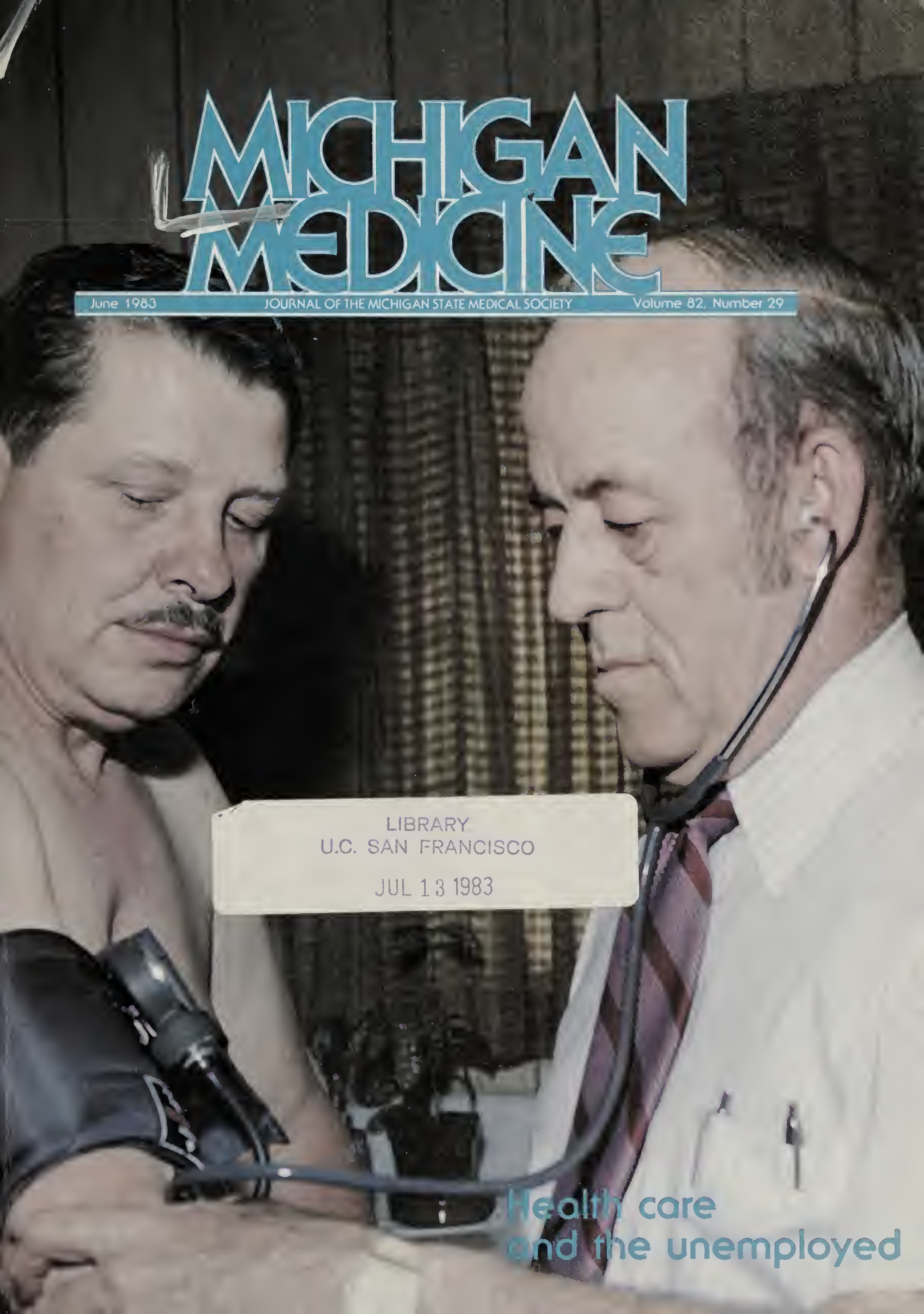

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Health care and the unemployed

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MICHIGAN MEDICINE
Health care and the unemployed

Kenneth J. Ray, MD, Trenton family physician, has been instrumental in providing health care for the unemployed in Michigan. His patient on our cover this month is Ralph Smith, Southgate. **(Photo by Rod Rieser)**

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Special report

352 What's happening to the unemployed when they need medical care? In many cases, county medical societies are organizing to assure that those who have lost health care benefits don't lose their health care. The federal government is proposing legislation to ensure continuation of needed health care for the unemployed, and MSMS leaders have formally expressed their concern. In most cases, *Michigan Medicine* has learned, the state's good doctors are personally assuring medical care is delivered, whether or not the people they serve have any financial resources. For details, see our special report inside; Willah Weddon

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Judith Marr

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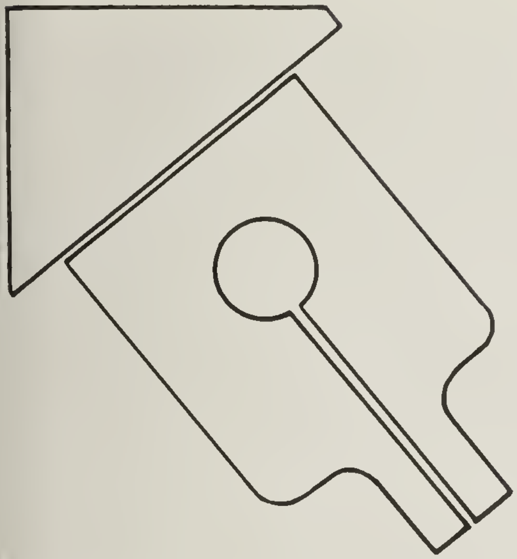
LETTERS



MSMS responsive

I am pleased to have made a contribution to *Michigan Medicine* which by all reasonable standards is an outstanding publication. It is informative as well as instructive.

I also want to take this opportunity to thank MSMS for its counsel, advice and cooperation during my tenure as director of the Michigan Department of Public Health.

Whether the issue was health care cost containment, maternal and infant care, toxic substances management, local health services or automobile restraints for infants, I could always depend on the full support and cooperation of MSMS, a progressive and responsive professional organization.

Few states can match that type of public-private sector cooperation for health promotion and the prevention of disease and disabilities.

Bailus Walker, PhD
Graduate Professor
Occupational and Environmental Health Science
Howard University
Washington, DC

Thanks to MSMS

The following letter was mailed to James Tisdel, MD, president, Michigan State Medical Society, 1982-83.

I want to thank you personally and on behalf of the Department of Ophthalmology for your kindness and thoughtfulness in representing the State Society at our naming and groundbreaking ceremony. Having been involved as a specialty society delegate with the Michigan delegation to the AMA, I had an opportunity to meet many of the leaders of organized medicine in Michigan. As you might gather, it is my strong feeling that the state's medical schools need to work closely with the state society, and your presence at our ceremony suggests that you feel the same way.

We hope that our eye center will serve as a resource for Michigan's physicians and patients and will be a source of pride to our state.

Paul R. Lichter, MD
Professor and Chairman
Department of Ophthalmology
University of Michigan
Ann Arbor

Private practice option

Despite recent increases in the number of practicing physicians, there are still areas of the country that are considered physician shortage areas. In such areas — often in rural communities, but also in certain urban or metropolitan centers — the population does not have adequate access to medical care and their medical needs are not being met.

A new physician recruiting source, the National Health Service Corps (NHSC) Private Practice Option aims to alleviate this situation. This program is especially effective because of the built-in physician incentives to practice in physician shortage areas. The American Medical Association is working closely with the NHSC on this program to locate communities or practices that would most likely benefit.

Each year several hundred new physicians become available whose training has been financed through the NHSC scholarship program. In return for these scholarships, the physicians agree to practice for a period of time in a federally-designated Health Manpower Shortage Area (HMSA). Under the private practice option, these physicians can now fulfill their obligations in the private sector if they establish a private practice in a Health Manpower Shortage Area. They can locate outside of a HMSA if 80 percent of their patients are from a nearby HMSA.

Last year, over 400 physicians took the OPTION and it is anticipated that more will do so in the next few years.

The physician's scholarship obligation may lead him or her to consider a practice opportunity that may have been ignored under other circumstances. And once established in a suitable private practice, the physician will be more likely to stay in the community.

The AMA's Department of Health Care Resources is working with state and local medical associations, medical specialty societies and various community groups to identify, evaluate, and promote these practice opportunities. If you have or know of such a practice opportunity and would like to help to recruit a physician, the AMA will be happy to provide this assistance.

For further information, please contact: Phyllis Kopriva, Program Director, Department of Health Care Resources, American Medical Association, 535 North Dearborn Street, Chicago, Illinois 60610, (312) 751-5111.

Generous gift

It is with pleasure that I acknowledge the receipt of your contribution of $100 to the Upper Peninsula Health Education Corporation for the George Wilson Memorial Student Loan Fund.

It was the wish of the Wilson family that these funds be used to assist our medical students through their temporary financial difficulties. Please be assured that your generous gift will be used exclusively for that purpose.

Jack L. Vantassel, MD
President
Upper Peninsula Health Education Corporation
Marquette

SPECIAL REPORT

Unemployed queue for job interview opportunity in Michigan.

County medical societies helping the “new poor”

By Willah Weddon
Stockbridge

The latest in a series of fastbreaking developments regarding health care for Michigan’s unemployed took the form of a resolution adopted May 1 by the MSMS House of Delegates.

The resolution encourages county medical societies to ensure availability of medical care to unemployed workers and their families.

Just prior to that, Henry M. Domzalski, MD, Wayne County Medical Society president, met with President Ronald Reagan in Washington, DC, along with AMA President William Y. Rial, MD, Michigan’s John J. Coury, Jr., MD, vice chairman of the AMA Board of Trustees and other medical society representatives from across the nation. The physicians told the president about the programs they’ve set up providing health care at no-cost, or low-cost, to unemployed workers with no health insurance.

The granddaddy

Among those cited were programs in Jackson, Muskegon and Wayne County Medical societies. The WCMS “Project Health Care,” created early in 1981, was the granddaddy of them all.

WCMS member and MSMS councilor Kenneth J. Ray, MD, Trenton, was instrumental in founding the project. He recognized unemployed workers were inclined to go without health care when they no longer were covered by insurance, could not pay for it from unemployment checks and were not eligible for government social service assistance.

One of the first states to be hit by a recession, when the automobile plants began closing in 1978, Michigan saw its unemployment rate increase until several cities in Michigan now have the highest unemployment rates in the nation.

In February, 1983, James H. Tisdel, MD, then MSMS president and chairman of the MSMS Committee on Humanitarian Services, issued an appeal for all county societies in areas of high unemployment to establish some type of medical assistance plan for families in this "new poor" group.

He cited "Project Health Care" as an example and urged primary physicians to work together to fill the need.

In an article for *Michigan Medicine* (July 1982), Doctor Ray described how Project Health Care was organized by the Greater Detroit Area Hospital Council in cooperation with the Wayne County Medical Society, Wayne County Osteopathic Society and several downriver hospitals.

Physicians volunteered to provide from one to 10 office visits a week and the hospitals agreed to provide their services at no cost when hospitalization was necessary.

$2 visit

An organization already in existence served as a referral center and did some screening to determine eligibility according to set guidelines. Some physicians charged nothing, while others charged a token fee of two dollars a visit.

A task force was set up and numerous private and public agencies contributed funds or in-kind contributions of assistance and services. This enabled them to hire a project director, project coordinator and project assistant.

Less than a year after the pilot program in downriver Detroit got underway, serving 16 communities, it was so successful that two other similar health service referral networks were established. They are a tri-county program serving the City of Detroit, the balance of Wayne County not served by the downriver project, Macomb County and the southern portion of Oakland County; and a North Oakland program serving the northern portion of Oakland County, including the city of Pontiac.

At the close of 1982 there were 310 physician volunteers and 75 hospitals involved in the three networks. From the inception of the project (July 1981) to February 1983, the Project Health Care, Health Services referral networks have received 4,572 calls. Of this total, 1,767 were referred to physicians, 1,551 to other programs and 75 to hospitals. Three hundred seventy-nine calls requested prescription assistance, 442 dental care, 371 vision care and 464 health insurance information.

Pamphlets available

To provide information, the Project Health Care developed, printed and distributed a pamphlet, "Maintaining Your Health While You're Unemployed." (A copy may be obtained from: Greater Detroit Area Health Council, Inc., 1900 Book Building, Detroit 48826.)

A directory of health care services in the seven county area also was compiled for professional use.

A $37,000 grant was awarded in April by the W.K. Kellogg Foundation to publish four sets of informational

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MSMS encourages care of unemployed

MSMS cares — about patients getting the best medical care — and about helping MSMS members deliver the best care.

To that end, the MSMS House of Delegates May 1 adopted a policy encouraging local medical societies to offer medical care for reduced or deferred payment to unemployed workers and their families.

The policy also included provisions for seeking alternatives to insure that medical care be available for those persons handicapped by unemployment and without health insurance benefits.

The full text of the resolution follows:

Whereas, the current economy of Michigan has left many workers unemployed and without medical insurance benefits, and

Whereas, these unemployed workers do not qualify for the usual governmental medical insurance benefits, and

Whereas, these workers have long been supporters of the free enterprise system of medicine; therefore be it

Resolved, That MSMS encourage local medical societies to offer medical care at a reduced or deferred payment to unemployed workers and their families without health care benefits; and be it further

Resolved: That MSMS seek alternatives to insure that medical care be available for those persons who are handicapped by unemployment and do not have health care benefits.

The MSMS Committee on Humanitarian Service earlier this year called on MSMS members to meet the health care needs of the unemployed.

Then MSMS-President James H. Tisdel, MD, Port Huron, who also serves as chairman of the Humanitarian Services Committee, wrote an open letter to MSMS members on the front page of the Feb. 10 *Medigram*.

"We are all aware of how the high unemployment rate has created a large pool of persons without health insurance," he wrote. "What you may not know is that many of these people are not eligible for social programs, such as Medicaid, because of the value of their personal property."

"I recognize that many of you already have made significant contributions and I applaud you for your efforts," he continued.

"However, the crisis continues, and I must ask you for further sacrifices.

"What I am asking is not as simple as writing a check. I am asking for a personal commitment from every physician, to shoulder part of the responsibility to meet the health care needs of the unemployed. It is a responsibility physicians cannot neglect."

materials, including updated editions of the original two pamphlets.

The Project Health Care Task Force worked with Blue Cross-Blue Shield to develop a low cost emergency care benefit package. It had a high deductible and could be purchased by an unemployed worker for about $75 a month. It was submitted to the Michigan Insurance Commissioner in July 1981, but is "still in the pending file," according to Symond R. V. Gottlieb, of the Greater Detroit Area Health Council, Inc.

In still another approach to the problem, Project Health Care stimulated and assisted a research program by the University of Michigan. A grant of approximately $250,000 was obtained from the Robert Wood Johnson Foundation to finance a study of the health needs and use of health services by the unemployed in Wayne, Oakland and Macomb counties. The University's School of Public Health is conducting the research and expects to have it completed by May, 1984.

Two more projects

Although PHC has included information on facilities in three other counties in its referral material, two of those county medical societies are setting up their own programs. Daniel J. Wilhelm, MD, St. Clair County president, proposed one in February.

"Forty doctors volunteered and the program is now set up," Doctor Wilhelm reports. "We're working through a crisis prevention center in Port Huron." Participating physicians accept referrals from the agency on a rotating basis and determine whether payment for services is to be gratis, token or deferred.

Washtenaw County Medical Society is in the process of setting up a referral system and has, so far, received between 20-25 percent response from their members.

In Genesee County, with one of the highest unemployment rates in the nation, the need for a health care system became recognizable when people started losing their benefits.

R.A. Dykewicz, MD, county medical society president, met with community representatives and sent a questionnaire in mid-February to physicians, proposing a plan similar to Project Health Care.

"The response was overwhelming. We had 112 physicians sign up for the plan, and it went into effect about March 1," according to Norman Anderson, executive director of the society.

By April 1, statistics supplied by the Crisis Center for the Unemployed, which serves as the referral center, revealed a total of 59 requests had been made for health services and a total of $2,155 in services had been supplied at no cost to the clients.

Clyde Davenport, MD, president of the Saginaw County Medical Society, worked with the United Way organization which set up an information and referral staff, to establish a program there on April 6. Within two weeks 75 people had been referred to the volunteer physicians. Ten percent of these had had family doctors.

"In some instances we ran across patients who had had family doctors, but had stopped going because they couldn't pay," the society's executive secretary said. "When their doctor found out about it, he was willing to take them free of charge."

Doctors care

Another area hard hit by the recession is Muskegon, ranking about fifth in the nation. In mid-February, the Muskegon County Medical Society established a "Doctor's Care" program to meet the health needs of the unemployed. Seventy-five percent of the physicians volunteered to take four or five cases a week.

A Central Referral Center was manned by Donald Fairfield, the MSMS executive secretary. He reports that 423 inquiries were received from February 17 to April 17. Members of the auxiliary have helped man the telephones and screen callers.

"We were deluged with about 40 calls a week at first, but now it's down to about two a day," Fairfield said. "Patients pay a $2 limit, if they have it."

"Some people who call say they're not going to see their doctor because they don't have the money," he continued. "But the doctors do want to see them. They care."

Early in 1982, Jackson County obstetricians recognized that, due to the economic situation, women were showing up at the hospital for delivery without having had pre-natal care.

"We knew there would be an increase in infant mortality without this care," Wayne A. Bare, MD, said. By June a program had been established with all delivering physicians in the county participating. The medical society executive director, R.W. Swartley, provided the referral center.

Under the program, all women are assured of pre-natal care and delivery, but it is not publicized as free care. Financial arrangements are left to the physician and patient, based on her ability to pay.

Ninety-nine obstetrical patients had been referred to physicians for care by May 1. Meanwhile, Doctor Bare has publicly stressed the importance of family planning during this period.

Coordinated effort

Jackson, Ingham, Clinton, Eaton, Hillsdale and Lenawee counties are included in the Michigan Mid-South Health Systems Agency. MMSHA has formed an advisory group bringing organizations together to help plan a coordinated effort to meet the needs of the unemployed in the region.

"We're thinking the problem will exist for a number of years," Ronald Parsons, executive director of MMSHA, said. "Even if the economy turns around, many people won't be going back to work because of the way companies have changed."

Within this framework, Ingham County Medical Society is looking into the possibility of setting up a program. ICMS has had an "adequate" response from members in a recent survey. Clinton County Medical Society works closely with the hospital which received $87,463 during 1982 for charity care under the Hill-Burton program. Lenawee County Medical Society members are "carrying a lot of people on their books," as are many rural areas across the state.

Kent County Medical Society has a committee looking into the possibility of organizing a program, but has not been hit as hard economically as have other parts of the state. The society is urging members to continue supporting their existing doctor-patient relationships with those who are unemployed.

CAT
DIESEL POWER

'I would not turn them down at this time' — MSMS member

Seventy-one percent of physicians provide free care or reduce their fees for patients who have recently become unemployed and lost their health insurance coverage, according to a survey conducted by the AMA Socioeconomic Monitoring System.

All MSMS members in a recent random sample reported they are caring for unemployed patients and their families. The unemployed most commonly made up approximately 10 percent of those physicians' practices, they reported.

Many of the sample physicians observed that those unemployed patients seemed to be delaying their routine care and waiting until they must see the doctor for more serious ailments.

This was despite the fact that most of the surveyed physicians described special arrangements they were making for unemployed patients to pay for their care. Some of these physicians were writing off payment completely, providing care gratis to those who could not pay.

Here is a sample of the arrangements described by the physicians surveyed for this *Michigan Medicine* report:

"I have practiced here 32 years — I would not turn them down at this time."

"They either qualify for Medicaid, General Assistance, or make payments when they can. If their accounts are one year old, we usually forget the charge."

"The entire college at MSU plans to help in a coordinated fashion."

"Delayed or reduced payments, depending on the situation."

"If they do not have insurance and can't pay, I will write it off."

"Some we are treating for gratis, some for a reduced fee. A crisis committee has been formed in the community to screen and refer."

"I believe that if a patient is in need of medical care it should be gratis; regardless of whether payment is received."

"We are making special arrangements when we find out these situations and deferring payments. Sometimes we supply them sample medications."

"No charge, and do much surgery under local anesthesia in the office; i.e., breast biopsies and hernia repair."

"Only if they mention they are unemployed; then there can be (1) no charge; (2) lower charge and/or (3) delayed payment."

The current health care crisis for unemployed workers is a new phenomenon, primarily affecting densely-populated areas where highly-unionized work forces have been receiving health insurance as a fringe benefit.

Reactions to organizing programs to provide health care for the recently unemployed-uninsured, varied in counties less affected by the declining economy.

A member of the Berrien County Medical Society's Executive Committee objected to being asked to take steps to see the unemployed receive health care, saying, "We have always done that and it's insulting to imply we don't." But it was pointed out in the BCMS County Bulletin: ". . . in recent years the interaction financially has been largely with third party payers. . . . Many physicians have little or no contact with collecting money. . . . If we are to maintain our traditional concern for our patients' well-being, . . . a conversation (about finances) may be necessary so that the financially embarrassed individual does not lack for medical care."

Duane L. Waters, MD, president of the Schoolcraft County Medical Society, points out that in the Upper Peninsula, "Providing health care for the unemployed it not a unique problem for us, because we have been doing it for years and years and years.

"Currently, the unemployment rate in the U.P. is 41 percent in Ontonagan County and here, close to 25 percent . . . chronically around 12 percent," he stated. "What this amounts to is that we have, most of the time, a relatively high accounts receivable."

In Bay County, where there is no organized effort to help the unemployed-uninsured, members of the county medical society are dealing with the high unemployment on an individual basis. Some of the physicians put a note in their statements, telling patients to contact the doctor if they are unemployed.

L.S. Kocur, MD, president of Lapeer County Medical Society says, "We have nothing organized here. But ours is a small community, people know each other, understand the problems and the physicians accommodate them individually."

Harry Schwartz says Medicaid the best coverage

Low-income families "who are covered by Medicaid have the best and most complete protection against medical expenses" of any group in the country according to a study by Harry Schwartz, PhD, a health economist at Columbia University.

On the average, people with family incomes below $5,000 are seeing doctors more often than any other income group. They also spend more days in the hospital than any other income group — twice as many days, for example, as people with family incomes of $25,000 or more.

The study, released by the National Center for Policy Analysis, evaluates traditional arguments in favor of national health insurance. One of the most frequent of these arguments is the claim that large numbers of Americans are denied the health care they need because they cannot afford it. This claim, according to Schwartz, is "a gross distortion of reality."

"Even the near poor — families who don't qualify for Medicaid — usually are not deterred from getting medical care," says Schwartz. The study found that "on the average, the lower a family's income, the more medical services it receives."

This is largely due to Medicare and the spread of private health insurance. "Over 94 percent of the American people are now covered by a private or public health insurance plan," according to the study.

The fact that Americans are generally not deterred from getting needed medical care for financial reasons has produced two results: one good; one bad. On the positive side, the study concludes that the "health of the American people has never been better." On the negative side, health care expenditures have increased almost 600 percent since Medicaid and Medicare were enacted in 1965.

Congress has shied away from passing a national health insurance bill, according to Schwartz, because it has been "fearful of enacting an even greater financial time bomb than Medicare and Medicaid have proven to be."

The study, entitled *National Health Insurance: A Pragmatic Perspective,* also looks at the health systems of other countries. It finds that national health insurance has not controlled costs.

In addition, countries with national health insurance invariably resort to rationing schemes which treat people in a discriminatory way and cause long waiting lists for treatment. The study concludes that in such countries, the quality of care declines and medicine becomes "more impersonal, more routine, and more bureaucratized."

Reagan's plan for unemployed

Members of the U.S. Congress are considering legislation to provide health insurance for the nation's unemployed. Proposals range from expanding existing federal health care programs to provide such coverage, to establishing programs that would require premiums to be paid on a proportion-to-income basis.

A five-point plan for medical assistance when needed by the unemployed has been approved by President Ronald Reagan and submitted to the Senate Finance Committee.

It would:

- Encourage private and state initiatives to provide health care for the unemployed;
- Permit states to use federal block grant funds to help finance the insurance initiatives;
- Raise federal revenues that will be available for block grants by lowering the proposed limit on tax-free employer contributions to group plans;
- Allow employed workers with individual health insurance to switch to family coverage that would include a spouse who had lost his or her job;
- Extend health insurance coverage for one year, after an employee is laid off, with the employee paying the premiums.

'I WOULD NOT'/*Continued*

The Kalamazoo Academy of Medicine is monitoring trends which might indicate a need for a program in the county. Local hospitals have reported about a four percent increase in no-pay care and one has noted that their major outpatient clinics are nearing capacity. At this time, however, a committee to investigate a "Doctor Care" program has recommended it be put on hold.

Ionia-Montcalm County Medical Society president, Leo W. Bunce, MD, points out there is no formal program as yet to take care of the unemployed. ". . . . these patients are usually seen by the family physician without a charge."

V. Dale Barker, MD, president of Oceana County Medical Society reports, "Our county has agreed that individual members will continue seeing their unemployed patients on an as-needed basis. If they can pay something, that's fine . . . and if they can't, they'll be continued under the doctor's care as usual."

Anxious patients improve in just a few days

And what is more reassuring to an excessively anxious patient than medication that promptly starts to relieve his discomforting symptoms? Valium® (diazepam/Roche) begins working within 30 to 90 minutes. Patients continue to improve in just a few days, and relief continues throughout the course of treatment.

There are other important benefits with Valium as well—along with its broad clinical range, Valium has an efficacy/safety profile that few, if any, drugs can match. This record has been achieved with extensive clinical experience, undoubtedly including yours. And, as you must have observed, side effects more serious than drowsiness, fatigue or ataxia rarely occur. Nevertheless, as with any CNS-acting agent, patients should be cautioned about driving, operating hazardous machinery or ingesting alcohol or other CNS-depressant drugs while taking Valium.

Yet another benefit Valium affords is flexibility. Available in 2-mg, 5-mg and 10-mg scored tablets, Valium enables you to titrate dosage to individual patient needs. For the geriatric patient, a starting dosage of 2 to 2½ mg once or twice a day is recommended. And, for patients who forget or skip medication, you can prescribe Valrelease™ (diazepam/Roche) 15-mg slow-release capsules, knowing that Valrelease will assure all the benefits of Valium 5 mg *t.i.d.* with the convenience of once-a-day dosage.

Discontinuation of Valium (or Valrelease) is typically as smooth as its start in short-term therapy. However, Valium and Valrelease should be discontinued gradually after more extended treatment. As you diminish dosage, the built-in tapering action of Valium and Valrelease will help avoid rapidly recurring anxiety symptoms and symptoms of withdrawal, and will help ease the patient's transition to independent coping when therapeutic goals have been achieved.

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For a summary of product information, please turn the page. ROCHE®

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Valrelease™ (diazepam/Roche) Ⓒ slow-release Capsules
Injectable Valium® (diazepam/Roche) Ⓒ

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Management of anxiety disorders, or short-term relief of symptoms of anxiety. Anxiety or tension associated with the stress of everyday life usually does not require treatment with an anxiolytic. Symptomatic relief of acute agitation, tremor, impending or acute delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in: relief of skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome. *Oral forms* may be used adjunctively in convulsive disorders, but not as sole therapy. *Injectable form* may also be used adjunctively in: status epilepticus; severe recurrent seizures; tetanus; anxiety, tension or acute stress reactions prior to endoscopic/surgical procedures; cardioversion.

The effectiveness of diazepam in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindications: Tablets or capsules in children under 6 months of age; known hypersensitivity; acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: As with most CNS-acting drugs, caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Withdrawal symptoms similar to those with barbiturates and alcohol have been observed with abrupt discontinuation, usually limited to extended use and excessive doses. Infrequently, milder withdrawal symptoms have been reported following abrupt discontinuation of benzodiazepines after continuous use, generally at higher therapeutic levels, for at least several months. After extended therapy, gradually taper dosage. Keep addiction-prone individuals (drug addicts or alcoholics) under careful surveillance because of predisposition to habituation/dependence.

> *Usage in Pregnancy:* **Use of minor tranquilizers during first trimester should almost always be avoided because their use is rarely a matter of urgency and because of increased risk of congenital malformations, as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.**

ORAL Advise patients against simultaneous ingestion of alcohol and other CNS depressants.

Not of value in treatment of psychotic patients; should not be employed in lieu of appropriate treatment. When using oral forms adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increase in dosage of standard anticonvulsant medication; abrupt withdrawal in such cases may be associated with temporary increase in frequency and/or severity of seizures.

INJECTABLE. *To reduce the possibility of venous thrombosis, phlebitis, local irritation, swelling and, rarely, vascular impairment when used I.V.: inject slowly, taking at least one minute for each 5 mg (1 ml) given; do not use small veins,* i.e., *dorsum of hand or wrist; use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Injectable Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Administer with extreme care to elderly, very ill, those with limited pulmonary reserve because of possibility of apnea and/or cardiac arrest; concomitant use of barbiturates, alcohol or other CNS depressants increases depression with increased risk of apnea; have resuscitative facilities available. When used with narcotic analgesic eliminate or reduce narcotic dosage at least 1/3, administer in small increments. Should not be administered to patients in shock, coma, acute alcoholic intoxication with depression of vital signs.

Has precipitated tonic status epilepticus in patients treated for petit mal status or petit mal variant status. Not recommended for OB use.

Efficacy/safety not established in neonates (age 30 days or less); prolonged CNS depression observed. In children, give slowly (up to 0.25 mg/kg over 3 minutes) to avoid apnea or prolonged somnolence; can be repeated after 15 to 30 minutes. If no relief after third administration, appropriate adjunctive therapy is recommended.

Precautions: If combined with other psychotropics or anticonvulsants, carefully consider individual pharmacologic effects—particularly with known compounds which may potentiate action of diazepam, *i.e.*, phenothiazines, narcotics, barbiturates, MAO inhibitors and antidepressants. Protective measures indicated in highly anxious patients with accompanying depression who may have suicidal tendencies. Observe usual precautions in impaired hepatic function; avoid accumulation in patients with compromised kidney function. Limit oral dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation (initially 2 to 2½ mg once or twice daily, increasing gradually as needed and tolerated).

The clearance of diazepam and certain other benzodiazepines can be delayed in association with Tagamet (cimetidine) administration. The clinical significance of this is unclear.

INJECTABLE. Although promptly controlled, seizures may return; readminister if necessary; not recommended for long-term maintenance therapy. Laryngospasm/increased cough reflex are possible during peroral endoscopic procedures; use topical anesthetic, have necessary countermeasures available. Hypotension or muscular weakness possible, particularly when used with narcotics, barbiturates or alcohol. Use lower doses (2 to 5 mg) for elderly/debilitated.

Adverse Reactions: Side effects most commonly reported were drowsiness, fatigue, ataxia. Infrequently encountered were confusion, constipation, depression, diplopia, dysarthria, headache, hypotension, incontinence, jaundice, changes in libido, nausea, changes in salivation, skin rash, slurred speech, tremor, urinary retention, vertigo, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances and stimulation have been reported; should these occur, discontinue drug.

Because of isolated reports of neutropenia and jaundice, periodic blood counts, liver function tests advisable during long-term therapy. Minor changes in EEG patterns, usually low-voltage fast activity, observed in patients during and after diazepam therapy are of no known significance.

INJECTABLE: Venous thrombosis/phlebitis at injection site, hypoactivity, syncope, bradycardia, cardiovascular collapse, nystagmus, urticaria, hiccups, neutropenia. In peroral endoscopic procedures, coughing, depressed respiration, dyspnea, hyperventilation, laryngospasm/pain in throat or chest have been reported.

Dosage: Individualize for maximum beneficial effect.

ORAL: *Adults:* Anxiety disorders, relief of symptoms of anxiety—Valium (diazepam/Roche) tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 Valrelease capsules (15 to 30 mg) daily. Acute alcohol withdrawal—tablets, 10 mg t.i.d. or q.i.d. in first 24 hours, then 5 mg t.i.d. or q.i.d. as needed; or 2 capsules (30 mg) the first 24 hours, then 1 capsule (15 mg) daily as needed. Adjunctively in skeletal muscle spasm—tablets, 2 to 10 mg t.i.d. or q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily. Adjunctively in convulsive disorders—tablets, 2 to 10 mg b.i.d. to q.i.d.; or 1 or 2 capsules (15 to 30 mg) once daily.

Geriatric or debilitated patients: Tablets—2 to 2½ mg 1 or 2 times daily initially, increasing as needed and tolerated (see Precautions). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose.

Children: Tablets—1 to 2½ mg t.i.d. or q.i.d. initially, increasing as needed and tolerated (not for use in children under 6 months). Capsules—1 capsule (15 mg) daily when 5 mg oral Valium has been determined as the optimal daily dose (not for use in children under 6 months).

INJECTABLE: Usual initial dose in older children and adults is 2 to 20 mg I.M. or I.V., depending on indication and severity. Larger doses may be required in some conditions (tetanus). In acute conditions injection may be repeated within 1 hour, although interval of 3 to 4 hours is usually satisfactory. Lower doses (usually 2 to 5 mg) with slow dosage increase for elderly or debilitated patients and when sedative drugs are added. (See Warnings and Adverse Reactions.)

For dosages in infants and children see below; have resuscitative facilities available.

I.M. use: by deep injection into the muscle.

I.V. use: inject slowly, take at least one minute for each 5 mg (1 ml) given. Do not use small veins, i.e., *dorsum of hand or wrist. Use extreme care to avoid intra-arterial administration or extravasation. Do not mix or dilute Valium with other solutions or drugs in syringe or infusion flask. If it is not feasible to administer Valium directly I.V., it may be injected slowly through the infusion tubing as close as possible to the vein insertion.*

Moderate anxiety disorders and symptoms of anxiety, 2 to 5 mg I.M. or I.V., and severe anxiety disorders and symptoms of anxiety, 5 to 10 mg I.M. or I.V., repeat in 3 to 4 hours if necessary; acute alcohol withdrawal, 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary. Muscle spasm, in adults, 5 to 10 mg I.M. or I.V. initially, then 5 to 10 mg in 3 to 4 hours if necessary (tetanus may require larger doses); in children *administer I.V. slowly*; for tetanus in infants over 30 days of age, 1 to 2 mg I.M. or I.V., repeat every 3 to 4 hours if necessary; in children 5 years or older, 5 to 10 mg repeated every 3 to 4 hours as needed. Respiratory assistance should be available.

Status epilepticus, severe recurrent convulsive seizures (I.V. route preferred), 5 to 10 mg adult dose administered slowly, repeat at 10- to 15-minute intervals up to 30 mg maximum. Repeat in 2 to 4 hours if necessary, keeping in mind possibility of residual active metabolites. Use caution in presence of chronic lung disease or unstable cardiovascular status. Infants (over 30 days) and children (under 5 years), 0.2 to 0.5 mg slowly every 2 to 5 min., up to 5 mg (I.V. preferred). Children 5 years plus, 1 mg every 2 to 5 min., up to 10 mg (slow I.V. preferred); repeat in 2 to 4 hours if needed. EEG monitoring may be helpful.

In endoscopic procedures, titrate I.V. dosage to desired sedative response, generally 10 mg or less but up to 20 mg (if narcotics are omitted) immediately prior to procedure; if I.V. cannot be used, 5 to 10 mg I.M. approximately 30 minutes prior to procedure. As preoperative medication, 10 mg I.M.; in cardioversion, 5 to 15 mg I.V. within 5 to 10 minutes prior to procedure. Once acute symptomatology has been properly controlled with injectable form, patient may be placed on oral form if further treatment is required.

Management of Overdosage: Manifestations include somnolence, confusion, coma, diminished reflexes. Monitor respiration, pulse, blood pressure; employ general supportive measures, I.V. fluids, adequate airway. Use levarterenol or metaraminol for hypotension. Dialysis is of limited value.

How Supplied:

ORAL: Valium scored tablets—2 mg, white; 5 mg, yellow; 10 mg, blue—bottles of 100 and 500; Prescription Paks of 50, available in trays of 10; Tel-E-Dose® packages of 100, available in trays of 4 reverse-numbered boxes of 25 and in boxes containing 10 strips of 10.

Valrelease (diazepam/Roche) slow-release capsules—15 mg (yellow and blue), bottles of 100; Prescription Paks of 30.

INJECTABLE: Ampuls, 2 ml, boxes of 10; Vials, 10 ml, boxes of 1; Tel-E-Ject® (disposable syringes), 2 ml, boxes of 10. Each ml contains 5 mg diazepam, compounded with 40% propylene glycol, 10% ethyl alcohol, 5% sodium benzoate and benzoic acid as buffers, and 1.5% benzyl alcohol as preservative.

ROCHE®

Patient should have part in decisions — conference message

By Kim Dean
Grand Rapids

"If there was one point we stressed over and over again — something we wanted all conference attenders to leave with — it was the vital concept of being sensitive to the pregnant woman's needs and desires. We wanted them to learn not only to allow her, but to encourage her, to take part in decision making."

These were the thoughts of Kenneth J. VanderKolk, MD, Co-Chairman of the Planning Committee for the 1983 Michigan Conference on Maternal and Perinatal Health.

Dr. VanderKolk emphasized that the overall goal of the conference was the presentation of a broad spectrum of topics in a "back to basics" format. It appears that this year's conference more than satisfied that goal. Over 550 guests filled the Grand Center/Amway Grand Plaza in Grand Rapids during each session of the two-day conference, as authorities lent insight into all aspects of perinatal care.

Ms. Dean is a free-lance writer and former MSMS student intern.

Sensitive period

In a session entitled "Responding to the Public," Marshall H. Klaus, MD, professor and chairman of the Department of Pediatrics, Michigan State University College of Human Medicine, addressed "The Status of Bonding — 1983."

In his discussion, Doctor Klaus noted that 16 out of 20 recent studies present evidence to support the idea that there is a sensitive period present in mothers and fathers in the first days and weeks of their child's postpartum life. This period may alter a mother's behavior for as long as two months after delivery.

Doctor Klaus stated that most mothers will not feel close to their babies for one week after delivery. This is a result of the re-identification process that occurs within the mother with respect to the type of child she delivers and the child she had envisioned over the nine month period. He emphasized the important role that health providers can play in helping their patients deal with this natural conflict.

In a lively session entitled "Work and Recreation in Pregnancy," recommendations were offered for pregnant women regarding sexuality, employment and recreation. It appears to be safe for women with normal pregnancies to maintain the same level of exercise they practiced prior to pregnancy, said Mona M. Shangold, MD, assistant professor of obstetrics and gynecology, director of the Sports Gynecology Center, New York Hospital/Cornell Medical Center. It should be noted, however, she said, that the long term maternal benefits from

Continued on page 361

Famous Pairs.

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And, when pain is a special problem, Anusol® Ointment offers the benefits of the topical anesthetic pramoxine HCl.

TUCKS® Pre-Moistened Hemorrhoidal/Vaginal Pads

The #1 hemorrhoidal** pad for added external relief and gentle cleansing.

☐ Soothes, cools, comforts, and cleanses irritated anorectal areas.

Once pain and inflammation subside, for dual action recommend regular ANUSOL® and TUCKS®.

Please see opposite page for brief summary of prescribing information.

*Meeting of Am Soc Colon/Rectal Surgeons, May 1980
**Data on file, Marketing Research Dept, Parke-Davis

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TUCKS®
Pre-Moistened Hemorrhoidal/Vaginal Pads

Hemorrholds and other anorectal uses — TUCKS extra-soft cloth pads allow for the gentlest possible application to tender, inflamed, hemorrhoidal tissue. TUCKS are effective cleansing pads for everyday personal hygiene Used on outer rectal areas, they remove residue that can bring on more irritation Pads are premoistened with 50% witch hazel, 10% glycerin USP and de-ionized purified water USP which acts as a cooling, soothing lotion to help comfort sensitive anorectal tissue.

Vaginal Uses — Comforting as an adjunct in postoperative care after episiotomies and other vaginal surgery or when relief from vaginal itching, burning or irritation is required.

ANUSOL-HC® SUPPOSITORIES
Hemorrhoidal Suppositories with Hydrocortisone Acetate

ANUSOL-HC® CREAM
Rectal Cream with Hydrocortisone Acetate

Caution: Federal law prohibits dispensing without prescription.

Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10 0 mg; bismuth subgallate, 2.25% bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%, Peruvian balsam, 1.8%, zinc oxide, 11.0 mg; also contains the following inactive ingredients: dibasic calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg, bismuth subgallate, 22.5 mg, bismuth resorcin compound, 17 5 mg, benzyl benzoate, 12.0 mg; Peruvian balsam, 18 0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Anusol-HC Suppositories and Anusol-HC Cream help to relieve pain, itching and discomfort arising from irritated anorectal tissues These preparations have a soothing, lubricant action on mucous membranes, and the antiinflammatory action of hydrocortisone acetate in Anusol-HC helps to reduce hyperemia and swelling

The hydrocortisone acetate in Anusol-HC is primarily effective because of its antiinflammatory, antipruritic and vasoconstrictive actions

Indications and Usage: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain, itching and discomfort in external and internal hemorrhoids, proctitis, papillitis, cryptitis, and fissures, incomplete fistulas, pruritus ani and relief of local pain and discomfort following anorectal surgery.

Anusol-HC is especially indicated when inflammation is present After acute symptoms subside, most patients can be maintained on regular Anusol® Suppositories or Ointment

Contraindications: Anusol-HC Suppositories and Anusol-HC Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparations

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts or for prolonged periods of time

Precautions: General: Symptomatic relief should not delay definitive diagnoses or treatment.

Prolonged or excessive use of corticosteroids might produce systemic effects.

If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued until the infection has been adequately controlled

Anusol-HC is not for ophthalmic use

Pregnancy: See "WARNINGS"

Pediatric Use: Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants

Dosage and Administration: Anusol-HC Suppositories — Adults. Remove foil wrapper and insert suppository into the anus Insert one suppository in the morning and one at bedtime for 3 to 6 days or until inflammation subsides Then maintain comfort with regular Anusol Suppositories

Anusol-HC Cream—Adults After gentle bathing and drying of the anal area, remove the tube cap and apply to the exterior surface and gently rub in For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides Then maintain comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories — boxes of 12 (N 0071-1089-07) and boxes of 24 (N 0071-1089-13) in silver foil strips with Anusol-HC printed in black.

Anusol-HC Cream — one-ounce tube (N 0071-3090-13) with plastic applicator

Store between 15° - 30° C (59° - 86° F).
1089G010

training must be weighed against potential fetal risks from metabolic, thermal and vascular alterations which occur during exercise.

Abuse begins

Controversies in Michigan regarding the small baby were addressed within four parameters, including practical care guidelines for both the neonate and fetus, ethical, and legal considerations. Every innovation is not necessarily an advance, noted Frederico G. Mariona, MD, director of Obstetrics and Maternal/Fetal Medicine, Hutzel Hospital/Wayne State University Perinatal Center, and Leonard L. Radecki, MD, co-director, Gerber Neonatal Intensive Care Unit, Butterworth Hospital, Grand Rapids, who spoke about the low birth weight fetus and neonate respectively.

The improved neonatal intensive care units have opened up new arenas for debate, and there is some question as to when appropriate care ceases and "abuse" begins, especially in infants weighing less than 700 grams. It is necessary to be able to individualize the treatment for both the parents and the infant and to address emotional needs and concerns as well as physical needs.

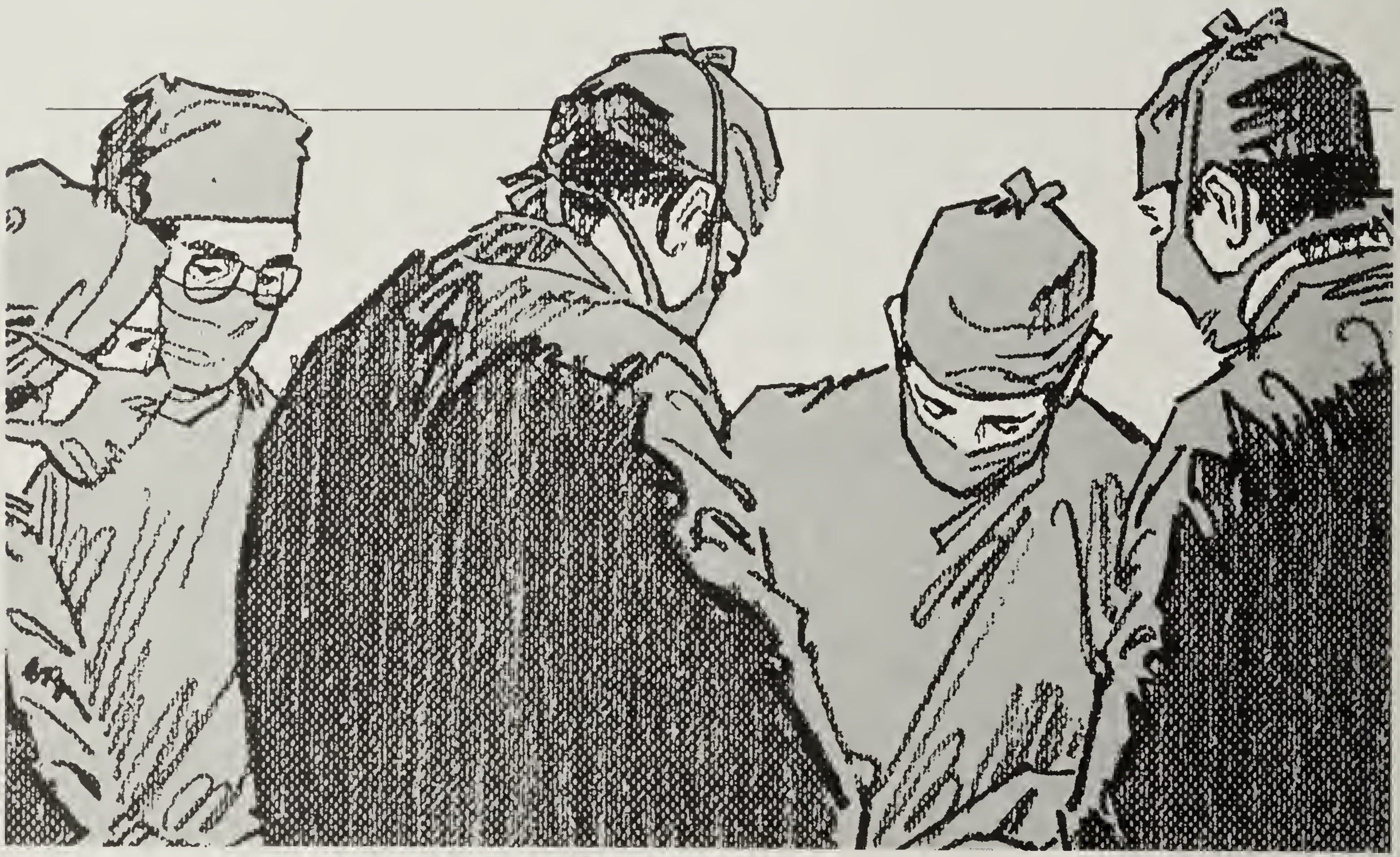
Howard Brody, MD, assistant professor, Family Practice and Philosophy; assistant coordinator, Medical Humanities Program, Michigan State University, furthered the discussion on ethical issues by addressing the proposed ethical guidelines of the American Academy of Pediatrics. In particular, he stated that in order to make the greatest percentage of right decisions in the future, practitioners should base decisions on several considerations: the best available medical data regarding diagnosis or prognosis; the parents' real and pressing interests when the infant's are not of the same magnitude; and recognition of the meaningful concept of futility. "Most importantly," said Doctor Brody, "decisions must be made in a setting that provides optimal emotional support to children, parents and professional staff."

In his discussions on sexually transmitted diseases in pregnancy, David Charles, MD, professor and chairman, Department of Obstetrics and Gynecology, Marshall University School of Medicine, issued a concern over adolescents and sexually transmitted diseases. Doctor Charles stated that not only will one out of 80 adolescents contract a sexually transmitted disease, but those adolescents will be among the 250,000 new cases of genital herpes that are reported each year.

Of interest is that chlamydia trachomatic, a tissue tropism affecting the conjunctiva and cornea, has overtaken gonorrhea in prevalence among sexually transmitted diseases. Approximately five percent of all women seen in family clinics have it and it is estimated to occur in one to four births out of 1000.

Mandatory insurance for MDs: Hospitals' move for protection

By Fred W. Bryant, MD
Royal Oak



Doctor Bryant was appointed by The Council as a study committee of one, to prepare this historical, informational report.

The physician sees himself put upon unfairly by an opportunistic legal system operating within a social scheme which asks too much and understands too little; and there is truth in this view.

The heart of the problem lies beyond medicine; so too, the solution.

Doctor Bryant is an ophthalmologist and MSMS director (councilor).

If society wants a huge compensation system, it must appreciate the price involved, determine its practical limits and spread the costs over a broader base. The very legal and legislative forces which now impose on the physician must be the source of his relief.

No issue, with the possible exception of third party reimbursement, persists longer or cuts deeper for the medical profession than does the malpractice issue. Frustrations are great, insecurities run deep and emotions flare high in relation to this enigma that the physician can neither solve nor ameliorate. Forcing physicians to pay for a system that's not working is not the solution to the problem. That is merely a device.

Meanwhile, Goliath grows!

The crisis

The medical malpractice crisis, as it was called in the mid 1970s, arose at a time when commercial insurance carriers were fleeing the field, and coverage, at least for some categories, was considered unavailable.

Corrective efforts, educational, legislative, and fiscal, were brought into play in an attempt to alleviate the

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problem. Physician-owned insurance companies were created during this period; at present, approximately 30 of them nationwide cover 110,000 physicians, representing 43 percent of the market.

Insurance coverage once more became available throughout the nation and, for a brief period in 1978 and 1979, malpractice actions seemed to level off. Recently, however, there is strong evidence that the crisis is in resurgence, this time not in terms of availability, but rather in the form of affordability.

The number of claims rises relentlessly. Twenty years ago in Florida one in 20 physicians had been sued; now it is one in five. In 1965, 31 percent of Ohio physicians had been involved in suit action in the previous five years; in 1981, the figure was 53 percent. Claims filed in Detroit jumped 53.7 percent between 1978 and 1980, and claims frequency in New York climbed 23 percent in one year (1982 compared to 1981). In California, a malpractice hotbed, one in five of all suits is for medical malpractice.

Awards grow

The size of awards and the cost of doing business are even more impressive. A study by the National Association of Insurance Commissioners reviewed 75,000 claims between 1975 and 1978; the average award rose from $26,000 to $42,000. In New York, the cost per closed claim involving indemnity payment is $357,000. Massachusetts, with only one previous million dollar award, reported ten at or near that figure in the year 1981. But California is still the champion, registering 59 percent of all cases in the nation over $1 million dollars.

Professional liability premiums, of course, reflect these adverse experiences. In New York, the Medical Liability Mutual Insurance Company, representing 18,000 physicians, asked for a 73 percent increase in rates in 1981. They were granted 26 percent and lost $200 million in 1982. Therefore, they again petitioned for a 73 percent increase in premiums. Also in New York, a state-run company asked for a 243 percent increment in premium rates; had it been granted, insurance would have cost a neurosurgeon $175,000 per year. Another request in Florida would have raised the annual premium costs of high-risk surgeons from $18,000 to $42,000. In both cases, the requests were denied and stopgap measures were instituted, but the issue is still pending. The A. M. Best Company, reporting a $60 million profit in 1977 found a $460 million loss in 1981. Underwriting losses, 110 percent when the commercial carriers defected in 1976, are now 150 percent (i.e., $1.50 is paid out for every $1 of premium taken in).

Reasons for the rising malpractice activity are legion, but a few may be mentioned here. Failure of legislatures to act, laws poorly conceived or poorly written, and erosion or reversal of laws already in place can be a factor. California has a new prejudgment interest law, entitling a plaintiff who receives a judgment in excess of his or her offer to settle, to collect 10 percent annual interest calculated from the date plaintiff first offered to settle the case. Since four or five years customarily pass before court cases are carried to completion, the size of the award may easily be increased 50 percent or more. Michigan's prejudgment interest statute precludes the collection of interest beyond the date a written offer of settlement is made by the defendant if the offer is substantially identical or substantially more favorable to the prevailing party than the judgment. The rationale for the laws is that they might serve as a court clearing procedure and an incentive to early settlement.

Traditionally, medical malpractice is tried under negligence law. There must be a duty, a breach of that duty, an injury and a causal relationship between the injury and the negligence which, in natural and probable sequence, produced the results. People used to sue doctors for deviating from accepted standards, but now they sue for misfortune as well. Malpractice has become maloccurrence. Lack of informed consent, listed as a cause of action in 21 percent of claims in Michigan prior to 1980, is at a level of 31 percent since that time. New theories of liability hold sway. "Wrongful birth" occurs where sterilization or contraception fails. In that event, the plaintiff is entitled to recover for pain, anxiety and the cost of pregnancy, but not for raising the child. In "wrongful life" where a physician may fail to predict a hereditary or incurable disease in utero and thus also fail to prevent or terminate pregnancy, he may be held liable for the lifelong support of the child.

With ready availability of expert witnesses, generous contingency fees (in Michigan one-third of the amount recovered) and present day public perception and jury attitudes, the prospect of early abatement of malpractice pressures seems poor.

Notably, a comprehensive reform enacted in Indiana in 1975 when Doctor Otis Bowen, a physician, was governor, has lowered malpractice activity. The package included a two-year statute of limitations from the time of occurrence, a ban on naming dollar amounts, pretrial screening panels, mandatory risk management programs and $500,000 cap awards.

The evolution of hospital liability

Vulnerability. Thirty years ago many hospitals were classified as charitable institutions deemed "judgment-free" on the theory that their resources should be preserved to perform those charitable acts. About that time, a court stated that hospitals could be sued for their non-trust assets. Shortly thereafter, another decided that hospitals were collectible to the extent that they were insured, customarily $10.000. Notably, in the *Darling* v *Charleston Community Memorial Hospital* case in Illinois in 1965, the court ruled that the hospital has legal obligations for negligent events on its premises, just like any other corporation. Viewed by some citizens as wealthy, impersonal and inept, the hospital has become a favorite target of defendant along with the physician and General Motors.

Size of Awards. In the middle of the 19th century, English Common Law held that no money could be recovered in the event of death. In 1865, through the efforts of Lord Ellington, an act passed Parliament allowing the imposition of damages, but limiting the amount. This concept was carried over into American law in the form of "death limits" and as late as 20 years ago figures in the range of $30,000 applied. In 1965 and 1966 a national movement to banish all ceilings on the size of awards succeeded, not un-

Continued on page 367

OFTEN INSEPARABLE: PAIN AND ANXIETY

A pathologic partnership one sees every day

Pain—triggering anxiety—which accentuates the perception of pain...together they're worse than either alone. And since they're usually both present in musculoskeletal disorders, the best therapy is often a combination of analgesic and anxiolytic agents. Equagesic®-M combines the pain relief of aspirin with the tension-reducing properties of meprobamate—because together they're better than either alone.

See important information on next page.

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Equagesic®-M

(meprobamate with aspirin) ⓒ Wyeth

Effective analgesic/anxiolytic alliance

Prompt, effective relief from the dual burden of pain and anxiety

tablets

Equagesic®-M

(meprobamate with aspirin) Ⓒ IV Wyeth

Effective analgesic/anxiolytic alliance

Proven superior to aspirin alone in controlled clinical trials

(BRIEF SUMMARY)

DESCRIPTION: Each tablet contains 200 mg meprobamate and 325 mg aspirin.

INDICATIONS: Adjunct in short-term treatment of pain accompanied by tension and/or anxiety in patients with musculoskeletal disease. Clinical trials demonstrated in these situations relief of pain is somewhat greater than with aspirin alone Effectiveness in long-term use, i e over 4 months, has not been assessed by systematic clinical studies Physicians should periodically reassess usefulness of drug for individual patients

CONTRAINDICATIONS: ASPIRIN Allergic or idiosyncratic reactions to aspirin or related compounds MEPROBAMATE Acute intermittent porphyria, allergic or idiosyncratic reactions to meprobamate or related compounds, e g carisoprodol, mebutamate, or carbromal.

WARNINGS: ASPIRIN Use salicylates with extreme caution in patients with peptic ulcer, asthma, coagulation abnormalities, hypoprothrombinemia, vitamin K deficiency, or those on anticoagulants In rare instances, aspirin in persons allergic to salicylates may result in life-threatening allergic episodes

MEPROBAMATE DRUG DEPENDENCE: Physical and psychological dependence, and abuse have occurred Chronic intoxication from prolonged ingestion of, usually, greater than recommended doses is manifested by ataxia, slurred speech, and vertigo, Therefore, carefully supervise dose and amounts prescribed and avoid prolonged use, especially in alcoholics and others with known propensity for taking excessive quantities of drugs Sudden withdrawal after prolonged and excessive use may precipitate recurrence of preexisting symptoms, e g anxiety, anorexia, or insomnia, or withdrawal reactions, e g , vomiting, ataxia, tremors, muscle twitching, confusional states, hallucinosis, and, rarely, convulsive seizures Such seizures are more likely in persons with CNS damage or preexistent or latent convulsive disorders Onset of withdrawal symptoms occurs usually within 12 to 48 hours after discontinuation, symptoms usually cease within next 12-to-48-hour period When excessive dosage has continued for weeks or months, reduce dosage gradually over 1 to 2 weeks rather than stop abruptly Alternatively, a short-acting barbiturate may be substituted, then gradually withdrawn.

POTENTIALLY HAZARDOUS TASKS Warn patients meprobamate may impair mental or physical abilities required for potentially hazardous tasks, e g , driving or operating machinery

ADDITIVE EFFECTS Since CNS-suppressant effects of meprobamate and alcohol or meprobamate and other psychotropic drugs may be additive, exercise caution with patients taking more than one of these agents simultaneously

USAGE IN PREGNANCY AND LACTATION: An increased risk of congenital malformations associated with minor tranquilizers (meprobamate, chlordiazepoxide, and diazepam) during first trimester of pregnancy, has been suggested in several studies. Because use of these drugs is rarely a matter of urgency, their use during this period should almost always be avoided. The possibility that a woman of childbearing potential may be pregnant at time of institution of therapy should be considered. Advise patients if they be-became pregnant during therapy or intend to become pregnant to communicate with their physicians about desirability of discontinuing the drug.

Meprobamate passes the placental barrier. It is present both in umbilical-cord blood at or near maternal plasma levels and in breast milk of lactating mothers at concentrations two to four times that of maternal plasma. When use of meprobamate is contemplated in breastfeeding patients, consider the drug's higher concentrations in breast milk as compared to maternal plasma levels.

USAGE IN CHILDREN Keep preparations with aspirin out of reach of children. Equagesic®-M is not recommended for patients 12 years of age and under

PRECAUTIONS: ASPIRIN. Salicylates antagonize uricosuric activity of probenecid and sulfinpyrazone Salicylates are reported to enhance hypoglycemic effect of sulfonylurea antidiabetics.

MEPROBAMATE. Use lowest effective dose, particularly in elderly and/or debilitated, to preclude over-sedation. Meprobamate is metabolized in the liver and excreted by the kidney, to avoid excess accumulation exercise caution in its use in patients with compromised liver or kidney function. Meprobamate occasionally may precipitate seizures in epileptic patients. It should be prescribed cautiously and in small quantities to patients with suicidal tendencies

ADVERSE REACTIONS: ASPIRIN May cause epigastric discomfort, nausea, and vomiting Hypersensitivity reactions, including urticaria, angioneurotic edema, purpura, asthma, and anaphylaxis may rarely occur Patients receiving large doses of salicylates may develop tinnitus

MEPROBAMATE CNS: Drowsiness, ataxia, dizziness, slurred speech, headache, vertigo, weakness, paresthesias, impairment of visual accommodation, euphoria, overstimulation, paradoxical excitement, fast EEG activity

GI Nausea, vomiting, diarrhea

CARDIOVASCULAR Palpitation, tachycardia, various forms of arrhythmia, transient ECG changes, syncope, hypotensive crisis.

ALLERGIC OR IDIOSYNCRATIC: Milder reactions are characterized by itchy, urticarial, or erythematous maculopapular rash, generalized or confined to the groin. Other reactions include leukopenia, acute nonthrombocytopenic purpura, petechiae, ecchymoses, eosinophilia, peripheral edema, adenopathy, fever, fixed drug eruption with cross-reaction to carisoprodol, and cross-sensitivity between meprobamate/mebutamate and meprobamate/carbromal Rare, more severe hypersensitivity reactions include hyperpyrexia, chills, angioneurotic edema, bronchospasm, oliguria, and anuria. Also, anaphylaxis, exfoliative dermatitis, stomatitis, and proctitis Stevens-Johnson syndrome and bullous dermatitis have occurred

HEMATOLOGIC (SEE ALSO "ALLERGIC OR IDIOSYNCRATIC"): Agranulocytosis, aplastic anemia have been reported, although no causal relationship has been established, and thrombocytopenic purpura

OTHER Exacerbation of porphyric symptoms

DOSAGE AND ADMINISTRATION: Usual dose is one or two tablets, 3 to 4 times daily as needed for relief of pain when tension or anxiety is present. Not recommended for patients 12 years of age and under

OVERDOSAGE: Treatment is essentially symptomatic and supportive Any drug remaining in the stomach should be removed Induction of vomiting or gastric lavage may be indicated Activated charcoal may reduce absorption of both aspirin and meprobamate. Aspirin overdosage produces usual symptoms and signs of salicylate intoxication. Observation and treatment should include management of hyperthermia, specific parenteral electrolyte therapy for ketoacidosis and dehydration, watching for evidence of hemorrhagic manifestations due to hypoprothrombinemia which, if it occurs, usually requires whole-blood transfusions Suicidal attempts with meprobamate have resulted in drowsiness, lethargy, stupor, ataxia, coma, shock, vasomotor and respiratory collapse Some suicidal attempts have been fatal. The following data, reported in the literature and from other sources, are not expected to correlate with each case (considering factors such as individual susceptibility and length of time from ingestion to treatment), but represent usual ranges reported Acute simple overdose (meprobamate alone). Death has been reported with ingestion of as little as 12 gram meprobamate and survival with as much as 40 gram.

BLOOD LEVELS:

0 5-2 0 mg percent represents usual blood-level range after therapeutic doses The level may occasionally be as high as 3 0 mg percent.

3-10 mg percent usually corresponds to findings of mild-to-moderate symptoms of overdosage, such as stupor or light coma

10-20 mg percent usually corresponds to deeper coma, requiring more intensive treatment. Some fatalities occur

At levels greater than 20 mg percent, more fatalities than survivals can be expected

Acute combined overdose (meprobamate with other psychotropic drugs or alcohol): Since effects can be additive, history of ingestion of a low dose of meprobamate plus any of these compounds (or of a relatively low blood or tissue level) cannot be used as a prognostic indicator

In cases of excessive doses, sleep ensues rapidly and blood pressure, pulse, and respiratory rates are reduced to basal levels Any drug remaining in stomach should be removed and symptomatic treatment given Should respiration or blood pressure become compromised, respiratory assistance, CNS stimulants, and pressor agents should be administered cautiously as indicated Diuresis, osmotic (mannitol) diuresis, peritoneal dialysis, and hemodialysis have been used successfully in removing both aspirin and meprobamate Alkalinization of the urine increases excretion of salicylates. Careful monitoring of urinary output is necessary, and caution should be taken to avoid overhydration.

Relapse and death, after initial recovery, have been attributed to incomplete gastric emptying and delayed absorption

HOW SUPPLIED: Bottles of 50 scored tablets

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like similar revisions for product liability and other categories.

Vicarious Liability. In an important 1978 court case, *Grewe* v *Mt. Clemens Hospital,* the Michigan Supreme Court held a hospital liable for the activities of an independent physician, greatly extending hospital responsibilities beyond normal employer-employee or ostensible agency relationships. In considering the case, the test of the issue is the patient's belief that "a third party" (physician) is another's (the hospital's) agent. Hence, the hospital is held responsible for the acts of all physicians within its confines. An extension of *Grewe* is that referring physicians may be held liable for the acts of specialists to whom they refer patients.

In *Hannola* v *City of Lakewood,* the court held the hospital liable for acts of negligence in the emergency room regardless of the contractual relationship with the physician.

The *Elan* decision in California stated that the hospital was liable for the acts of negligence of the medical staff of the hospital if it: (1) granted privileges to an incompetent physician, (2) negligently renewed staff privileges for an incompetent physician or (3) failed to monitor adequately a physician's clinical performance. This exposes the hospital to litigation for almost any alleged physician act of negligence within its chambers.

Joint and Several Liability — "The Deep Pocket Concept." Joint and several responsibility, a time-honored tenet of jurisprudence, was expanded by California Supreme Court action in 1978 broadening accessibility to defense resources. In the *American Motorcycle Association* v *Superior Court of Los Angeles County,* the court held in a case involving more than one defendant that: (1) the jury would allocate fault among the defendants, (2) the plaintiff could collect the entire judgment from any one of the defendants, (3) when one defendant settles out of court, the settlement does not affect the total amount of the judgment that can be collected, (4) a defendant has the right to bring into the case any other defendant and (5) a defendant who is required to pay more than his or her share of the judgment can attempt to collect from the other defendants.

Vicarious liability and joint and several liability expand and connect responsibilities and may result in cross claims and third party actions taken by one defendant against another. This serves to accentuate the inequities between "covered" and "bare" physicians for they are not only liable to the plaintiff, but also to fellow defendants and their insurance companies. The "bare" physician is safe only if he has no attachable assets, and even then, others may shy away from him because they are liable for his acts.

Thus, in little more than a century, award possibilities changed from zero to infinity. In one-half that time, hospitals have gone from a position of complete immunity to one of unlimited responsibility for virtually all acts by all physicians within their walls. Such has been the trend.

Mandatory considerations

Under these circumstances, it is not surprising that hospitals have moved to safeguard their interests and those of their patients and to insist physicians carry insurance protection to meet their responsibilities. Disputes have arisen between physicians and hospitals over the issue of compulsory insurance requirements. Some have been carried into the courts. When this occurs, the way the court views the status of the hospital is of importance.

Legal Standards for Hospitals

1. Purely private institutions are obligated only to follow their own bylaws, enacted for the betterment of the institution. Traditionally, courts have refused to review administrative decisions of private hospitals unless they violate the rules or bylaws of the hospital.

2. "State Action" institutions include:

   a. Public hospitals

   b. Private hospitals regarded as public because of receipt of tax benefits or governmental monies such as Medicare, Medicaid, and Hill Burton Construction Funds and

   c. Those deemed to be in a fiduciary relationship with the community so that their responsibilities must be exercised for the public good.

The significance of the finding of state action is that hospital conduct must conform to the standards of due process and equal protection as envisioned in the 5th and 14th Amendments to the Federal Constitution and may not be unreasonable, arbitrary or capricious.

Drafting the Bylaw. In an effort to avoid appearing unreasonable, arbitrary or capricious, the hospital may: (1) assist the physician in obtaining insurance or even provide programs wherein physicians may purchase coverage from the hospital, (2) conduct periodic checks to see that physicians have insurance in force and to allow grace periods for them to report a loss of insurance or to obtain new coverage, (3) excuse physicians from the regulation if insurance is unavailable or its cost prohibitive and (4) allow physicians to use some alternate financial means (other than commercial insurance).

Arguments Against Such a Bylaw. Physicians may object to insurance requirements on moral or financial grounds claiming that: (1) it has no relation to the physician's ability to practice medicine, (2) the hospital has no right to require financial responsibility of physicians, and (3) it is unaffordable or places undue hardship on the physician.

The Legality of Compulsory Malpractice Insurance. About a dozen states already have laws in place which require physicians to carry insurance; Michigan is not one of these. Although 42 percent of the hospital beds in the state already fall under bylaws with obligate insurance requirements, no court case has surfaced in Michigan to date or in the Sixth Circuit, of which we are a part. The issue has, however, been tested a number of times nationwide. Virtually every decision supports the hospital's right to impose a mandatory insurance requirement on the physician if it is properly stated in the bylaws.

In *Holmes* v *Hoemako Hospital,* considered a landmark case, the physician objected to a provision of private medical staff bylaws which provided "all staff members shall have and maintain insurance of a kind and amount required and approved by the governing body." In applying the standard, the court examined the

Continued on page 368

reasonableness of the requirement and recognized the need for malpractice insurance. "We cannot ignore realities of modern, procedural practice. If a patient is injured in a hospital, regardless of who is at fault, the hospital will almost always be joined as a co-defendant. Despite the outcome of such an action, the hospital must expend valuable financial resources in its own defense and will, if innocent of wrongdoing, be more likely to recover its expenses from the tort-feasor (participant) physician, if that physician is insured."

The hospital argued that it had the right to take reasonable measures to protect itself and the patients it serves, that a physician's failure to carry insurance might impair the doctor's ability to compensate patients, the hospital's insurance would be more costly, and that patient care might be adversely affected by doctors avoiding treatment of patients with serious medical or surgical problems. The court concluded: "The rule is reasonable on its face. We can envision situations, however, where such a rule would not be reasonable in its application." It did not elaborate.

In *Renforth* v *Fayette Memorial Hospital Association*, a physician objected to the insurance requirement solely as a matter of principle and in *Pollock* v *Methodist Hospital*, another contended that the requirement, regardless of amount, was unreasonable. Both cases were decided against the physician and in favor of the hospital. Therefore, it seems clear, by court precedents, that hospitals have the right to impose reasonable insurance requirements on the medical staff. In both *Renforth* and *Pollock* the physicians objected purely as a matter of principle and no mention was made that the amount was unreasonable or that undue hardship resulted.

Physician positions

American Medical Association

In 1965 the AMA House of Delegates approved the following policy statement: "Doctors should be encouraged to carry professional liability insurance that is adequate. However, this encouragement toward self-protection should come from local medical societies and not as a result of coercion on the part of a hospital. There are legal as well as professional reasons why the evaluation of a physician's qualifications for staff privileges should not, in effect, be delegated to an insurance company."

The Board of Trustees was of the opinion that each hospital medical staff should determine for itself whether it will require professional liability insurance coverage at the commonly prevailing level of policy limits as a condition for membership on the hospital medical staff.

Wayne County Medical Society

An official policy statement adopted October 13, 1982 reads: "The decision of compulsory liability insurance as a requirement for hospital medical staff privileges and the limits of such insurance coverage should be a decision mutually agreed to by the hospital staff and the hospital board of trustees."

Joint Commission for the Accreditation of Hospitals and The American Hospital Association

Neither organization has an official policy on this subject.

Suggested Implementation. If the hospital chooses to invoke mandatory insurance requirements for medical staff membership, it would be wise to: (1) understand the emotional nature of the issue and the danger of estrangement between hospital and staff, (2) conduct preliminary groundwork to educate and involve the leadership of the medical staff in the strategy, (3) present a cooperative program designed to accomplish mutual agreement between hospital and physician, (4) protect the physician performing hospital functions such as peer review and emergency room duties assigned by the hospital and (5) consider a position of moderation and flexibility; physicians are not equal in their involvement with the hospital and in their vulnerability to malpractice actions, but vary greatly in age, specialty, intensity of practice, health and scope of medical activities.

The MSMS House of Delegates set new policy for the medical society on the issue of mandatory professional liability insurance when it met April 29-May 1 this year.

The delegates passed a four-part resolution:

1) They placed MSMS on record as being opposed, unalterably and unequivocally, to unilateral and arbitrary hospital governing board edicts that mandate professional liability coverage as a requirement of hospital staff membership when these edicts are passed without medical staff approval or acceptance.

2) They said the decision to require professional liability insurance as a requisite for hospital medical staff privileges and the limits of such insurance coverage should be a decision mutually agreed upon by the hospital medical staff and the hospital board of trustees.

3) They declared that physicians who are unable to obtain professional liability insurance and otherwise are in good standing with the board, hospital and staff shall not automatically be denied privileges. They called on MSMS to investigate methods for continuing coverage at reasonable rates by insurance companies in these cases.

4) They asked MSMS Board of Directors (Council) to notify the Michigan Hospital Association of MSMS awareness of the two groups' medical liability differences and to elicit MHA cooperation to develop guidelines for physician/hospital medical liability insurance.

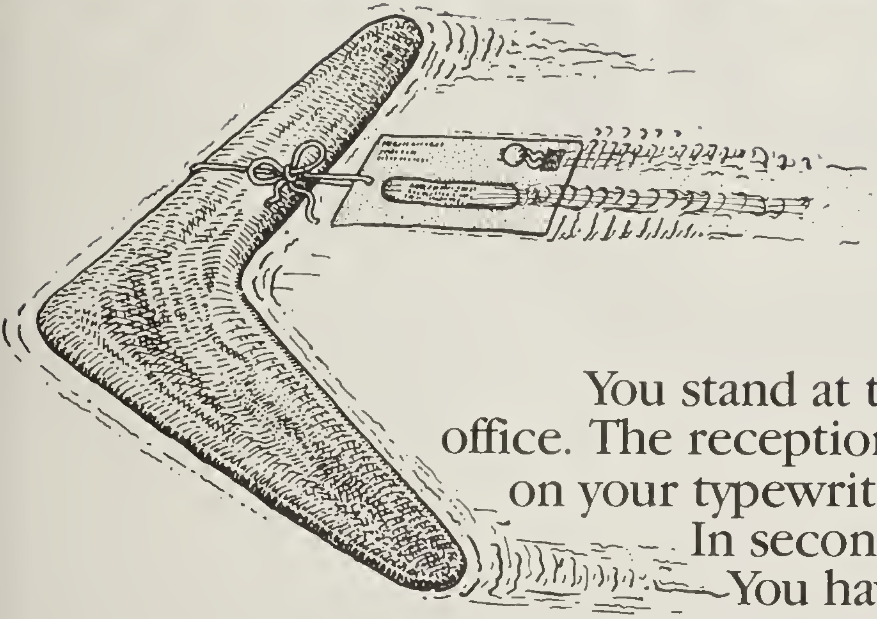
At present, nearly one-half the hospital beds in the State of Michigan are self-insured. There is irony here.

The hospital may move to force physicians to join a compulsory system while the hospital remains self-insured. While it is by no means always the case, there is evidence that self-insured hospitals tend to settle more quickly, and, on average, pay more than those commercially insured.

The hospital may not morally merely use physicians as a cushion for itself. For the system to work, all aspects of the defense must be competent. On the other hand, a single combined defense, if well-managed and coordinated, can be stronger than individual defenses proceeding separately.

The physician, if he is joined into such a system, would function best in a position of equality, providing safeguards and protections, insofar as they are practical, and taking an active role in determining positions and policies.

SNAPPY RETURNS.



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WORTH SHARING

The physician and the politician with apologies to Aesop

By Franklin V. Wade, MD
Flint

The following is reprinted from the Genesee County Medical Society Bulletin.

Once upon a time there lived in the land a humble physician. He was loved by the people and he toiled very hard each day to heal the sick. There also lived in the same land a politician. This man talked with a loud voice and smiled a lot. The people listened in awe at his wonderful words.

One bright summer day while the humble physician was making his daily rounds he chanced upon the politician busily shaking hands with the people who listened in awe to his wonderful words. The politician greeted the physician, calling him by name and smiling broadly.

The politician took the physician by the arm and said: "Dear and kindly physician, how would you like all good things for your patients? Would you like to take care of the poor and suffering with freedom and compassion and still make the good living you so richly deserve? Would you like to have less oppressive taxes and less regulation from the government?"

The humble and kindly physician thought for a moment and said: "Yes, I would like that for the people and for myself." "Fine!" beamed the politician, "If you could place 100 guilders in my coffers I promise you that when I reach the councils of the mighty all these things and more will come to you." The humble physician withdrew his leather money purse and counted 100 guilders into the palm of the smiling politician. The physician went on his rounds with a light heart confident that good things would come to his people. The politician went away shaking hands and saying wonderful words.

And so it came to pass the politician did indeed achieve a place in the council of the mighty and there he wrought many marvelous things. He causes to be passed many laws. He caused taxes to be raised and new taxes to be levied. He brought forth the Single Business Tax and did increase the income tax and reduce Social Security Benefits. He brought forth OSHA and a marvelous law called the Health Planning Act. He created the Federal Trade Commission and gave it power to regulate everything. He caused vast amounts of the treasury to be spent on nuclear powered air craft carriers and many other marvelous instruments of destruction. The politician made many journeys to exotic lands and told of wondrous things and caused great stores from the treasury to be shipped to far away places so their people will be friendly to our people.

After many months had passed the humble physician was once again making his rounds healing the sick. Again he did chance upon the politician who was shaking the hands of the people as they listened in awe to his wonderful words. The politician greeted the physician, calling him by name and smiling broadly.

He took the physician by the arm and said: "Dear and kindly physician, I have toiled lo these many months in the councils of the mighty. I must now ask you once again to help me help the people. I promise to lower taxes, to give freedom and bring happiness and prosperity to all. Dear and kindly physician," beamed the politician, "If you could spare me 200 guilders (inflation you know) for my coffers I promise you when I again reach the council of the mighty all these things and more will come to you and your people."

The humble physician thought for a moment, heaved a heavy sigh, and withdrew his worn leather purse and counted 200 guilders into the waiting palm of the smiling politician.

Moral #1: It takes a lot of humble physicians to make a successful politician

Moral #2: There's a sucker born every minute.
—P.T. Barnum

Comment: As some of you may have suspected, I'm a little short on morals. I'm sure there is a better moral in this story somewhere. A reward of 50,000 farthings to the reader who can come up with the most appropriate moral.

Doctor Wade is past president of the Genesee County Medical Society.

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Don and Nancy Crandall. (Photo by Greg Dorsett, *Muskegon Chronicle.*)

Profile of the MSMS President

'Family involvement is a way of life'

By Dave Alexander
Muskegon

On the job, in the home or at church, Donald and Nancy Crandall have taught their three sons (by example) that it is important to get involved in their community.

Nothing symbolizes that involvement more than the Muskegon surgeon's induction as MSMS president April 30. Serving his profession through the Society has been a time-consuming activity since Doctor Crandall set up practice in Muskegon in 1970.

"I feel a strong obligation not only to my patients and practice but also to my profession," he said of taking the Society post. "It is a way of serving the profession.

"Nancy and I feel the same way about the community as I do about the profession," he added, "You have a responsibility to make it the best you can."

While Doctor Crandall has used all of his spare hours to assist the society on the local, state and national levels, Mrs. Crandall hasn't been idle.

A member of the Norton Shores City Council, she also is active in the MSMS Auxiliary as vice president, in Planned Parenthood, the YFCA and the League of Women Voters. The family also is active in the Central United Methodist Church.

At times, the couple's three sons must think civic meetings can't be conducted without one of their parents being present. However, the Crandalls find plenty of time for family-oriented activities with 19-year-old Ken, 17-year-old Keith and 15-year-old Brad.

Doctor Crandall, a member of the Muskegon Surgical Associates, began to serve the Society in 1972 as a delegate at the state level. He led the MSMS negotiating committee with third party payers.

His involvement in the committee led to giving seminars for the American Medical Association on negotiations with Blue Cross/Blue Shield, government Medicaid and Medicare programs and private insurance companies.

From 1974 to 1980, Doctor Crandall and the negotiating committee worked on a uniform coding system and claim forms. To date, the work has had results, Doctor Crandall says. There used to be a 15 to 20 percent error rate in processing insurance forms; but this has been reduced to around five percent, he said.

Doctor Crandall was a Michigan delegate to the AMA in 1976 and served as the Muskegon County Medical Society president in 1979.

For the immediate future, he has a busy year ahead.

"The medical society is facing a very serious challenge," he said.

Dave Alexander is the health and hospitals writer for the *Muskegon Chronicle.*

"There will be rapid changes in the next five years."

With federal regulations, a surplus of physicians and technology advancing "at a greater rate than society is willing to pay for it," the society will face some formidable problems in the coming year, Doctor Crandall said.

"I see my job as educating physicians about the impending changes and communicating these changes to organizations outside the Society," he said, "There is a movement in society to demand more 'touch' and the medical profession will have to adapt to this."

He cited the movement back to general practitioners and family practice, store front emergency care centers and hospice care for the terminally ill as reactions to the high technology patients have faced in recent years.

In the 1960s the medical profession looked at the health needs of the patient, while in the 1970s the profession became concerned with societal needs like home health services, Doctor Crandall said. However, in the 1980s, physicians must be concerned with the economic factors.

"That is going to require a change of attitudes in physicians — to think about cost-effective care," Doctor Crandall says.

But the main concern still must be quality of care. "If we are going to lose quality, I'm going to express concern about the changes," he says.

Specifically, Doctor Crandall will direct the Society during a time when the issue of professional liability will resurface with a package of bills pending before the state legislature. The society also will continue to push for mandatory seat belt laws, now that the legislature has acted on tougher drunk driving laws and child restraint legislation.

More generally, the society will watch Gov. James Blanchard's economic recovery program. Health being one of the top five industries in Michigan, physicians have quite a stake in the state's economy, Doctor Crandall says.

His future involvement in the Society will be on the national level, he says.

The Crandalls came to Muskegon from Detroit after he finished four years of studying general surgery at

The Crandalls on the eve of Doctor Crandall's installation as MSMS President, April 30, 1983. From left, Brad, 15; Ken, 19; Nancy, Don, and Keith, 17.

Doctor Crandall and team perform a parathryoidectomy.

Doctor Crandall catches up his patients' records.

the Detroit Medical Center at Harper Hospital. That followed two years in the Naval medical corps, an internship at Bon Secours Hospital in Grosse Pointe, a medical degree from the University of Michigan and a bachelor's degree from Albion College.

"One thing that we talked about when we discussed leaving Detroit was that it was hard to contribute there," Doctor Crandall said. "Here, you just have to stand up and raise your hand. People are involved from all walks of life. There is a willingness to accept you."

Doctor Crandall's father Maynard, now retired in Warren, was a pharmacist. With that exposure to the medical professions, he knew since seventh grade that he wanted to be a doctor.

"I had a long talk with my counselor (in junior high school) and he told me I would never make it," Doctor Crandall remembered from his home atop a 30-foot bluff overlooking Lake Michigan. "He told me to learn a trade. I told him, 'No thanks, I'm going to be a doctor.'"

It was at the University of Michigan Medical Center that the Crandalls met. Mrs. Crandall was a nurse on the pediatrics floor after receiving her nursing degree from Indiana University. They were married in 1962.

"I was born too early," Mrs. Crandall says. "It was before women learned they could be something other than a teacher or a nurse."

Although she hasn't worked as a nurse for 18 years, Mrs. Crandall said being "in the profession" helps her to understand her husband's long hours and dedication. "When he rushes off, it gives me a better idea of what he is doing and why," she says.

The Crandalls have decided to make Muskegon their permanent home.

"We are here for the duration," Mrs. Crandall says. Dr. Crandall plans to continue with the Muskegon Surgical Associates as the practice grows and expands.

It was the medical opportunities and the Muskegon lifestyle that prompted the Crandalls to move from Detroit. The couple said they knew their home would be in western Michigan. But why did they settle on Muskegon?

Doctor Crandall points out his living room window to Lake Michigan. The medical community prompted them to select Muskegon over some other cities on the Lake Michigan shoreline, he says.

"Muskegon really has an outstanding medical community as far as facilities go," he said, adding he has staff privileges at both Mercy and Hackley hospitals. "It has all of the support labs and X-ray technology."

The Crandalls said Muskegon is a fine place to raise a family.

"We like the idea of living in a community that is minutes from a vacation land," Mrs. Crandall said. The family seems to thrive on outside activities. They have a Hobie Cat sailboat on the beach, all ski in the winter and play golf, tennis or jog in the summer.

The Crandalls seem to be a perfect example of the philosophy of parents providing children "quality time" instead of quantity of time.

"The boys understand fully what we are doing," he says. "And they see the need for it . . . our family involvement is a way of life."

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MSMS offers these guidelines for physicians considering PPOs

Although there is currently only one preferred provider organization in operation in the State of Michigan, several major employers and third parties are actively discussing the formation of this type of financing system. With this in mind, the MSMS House of Delegates at the direction of the MSMS Council, has approved the following statement about PPOs to provide physicians with some guidance when they analyze this type of financing system.

MSMS does not have a position either favoring or opposing the actual concept of PPOs, but rather allows individual physicians to evaluate these organizations based on their own individual situations.

MSMS Statement on PPOs

Preferred Provider Organizations in Michigan should promote fee-for-service medicine, balance the marketing advantages of other financing mechanisms and encourage innovations to control health care costs.

Physicians analyze Preferred Provider Organizations based on the following guidelines:

1. The PPO plan must assess and maintain quality care by a physician-controlled peer review mechanism.

2. The PPO plan should address overall health care costs to the community including medical education, tertiary care facilities and catastrophic illness. It should not merely be a cost cutting mechanism within its select population.

3. The PPO plan must assure the physician's role as the advocate of the needs of each patient. The physician should not be placed in an adversary position by acting as an agent for the health plan.

4. PPO planning must recognize the role of the physician as the expert in selecting health care for his patients. He should select an overall cost effective treatment plan rather than provide services based solely on lowest cost.

5. The PPO plan should reinforce the concept of a continuing relationship between physician and patient.

6. Physicians must be intricately involved in the planning, organization and management of all plans involving the delivery of health care services.

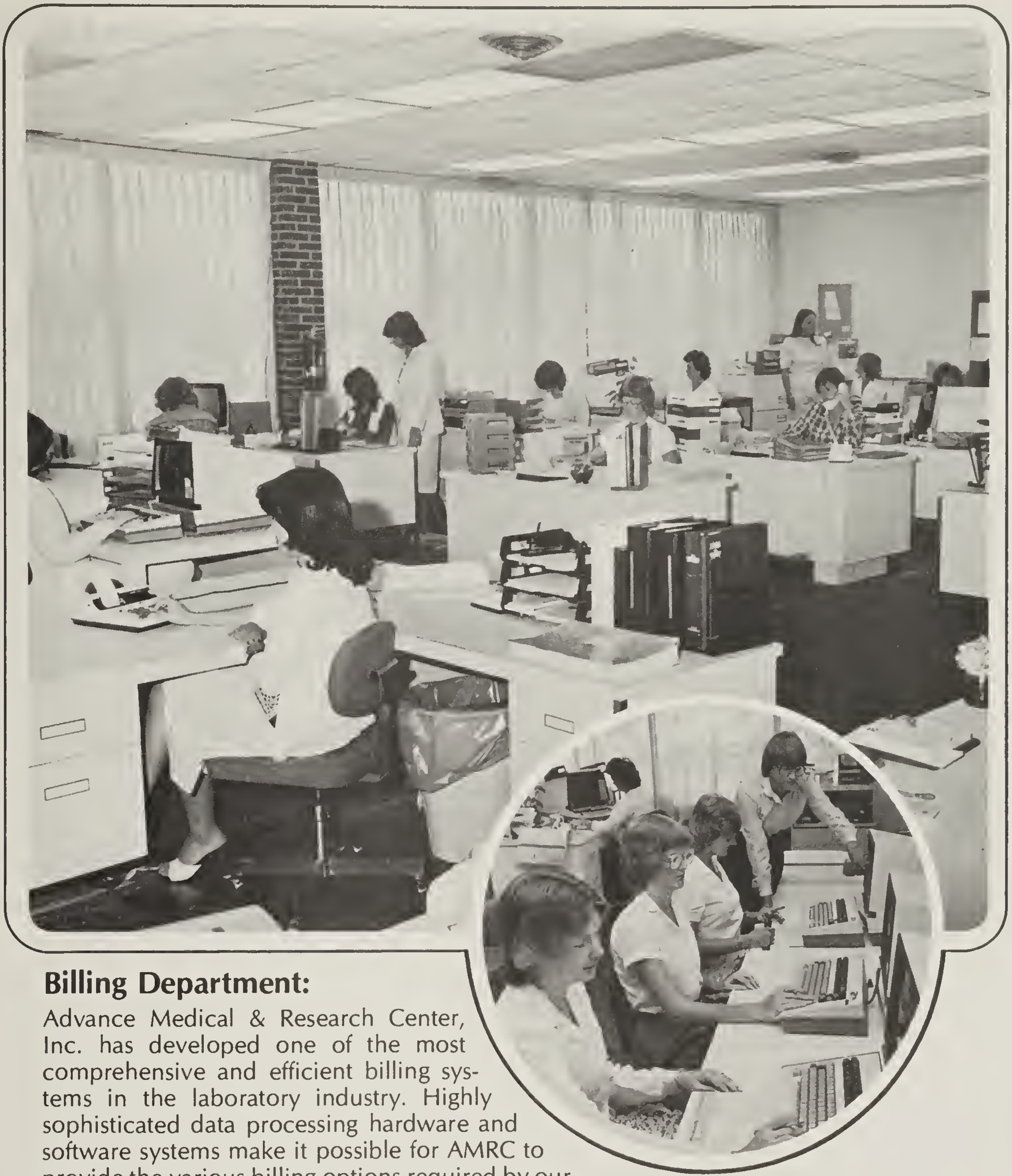
7. PPO plans should provide incentives for consumers to make cost effective choices for their own health care.

8. Physicians should have access to detailed information concerning their own "practice profile."

9. Advertising for any PPO must be fair, objective and truthful. It should clearly state any limitation in services to be delivered.

10. All PPO plans should make provisions for "freedom of choice" of physician by the individual patient. This should be accomplished by including reasonable copays and deductibles for patients using physicians outside the plan.

11. Preferred provider plans should furnish a mechanism for incorporation of new physicians into their organization.



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MSMS survey finds many hospitals require MDs to have insurance

By Gary D. Maynard, MD
Kalamazoo

The MSMS Medical Staff Relations Committee has recently tabulated the results of its January 1983 survey of the chiefs-of-staff of Michigan hospitals.

Our committee gratefully acknowledges the chiefs-of-staff who responded to the MSMS survey. We are pleased to have received a 64.2 percent response to its survey, allowing us to tabulate 140 completed questionnaires from the 218 hospitals polled. This information is extremely valuable in dealing statewide with the many issues that we confront individually.

Some of the interesting results of the survey include:

- 42 percent of the hospitals responding to the survey have mandatory insurance as a prerequisite for hospital privileges
- 83 percent of the hospitals responding to the survey have physician representatives on their Boards of Trustees and
- 24 percent of the hospitals responding to the survey have satellite clinics.

We are glad to share the results with you below.

Note: In addressing the question of care of the hopeless/moribund patients, the Committee received guidelines from several hospitals. If you are interested in receiving a set of guidelines, we would be glad to share them with you. Write to William Madigan at the Michigan State Medical Society, P.O. Box 950, East Lansing 48823.

Survey of Michigan Hospital Chiefs-of-Staff Results, January 1983

	(57)		(83)		(140)	
	100 beds & under		100 beds & over		Composite	
1. How often is your chief-of-staff elected?						
Annually	40	(70%)	34	(41%)	74	(53%)
2 years	17	(30%)	40	(48%)	57	(41%)
3 years	0		7	(8%)	7	(5%)
Other	0		2	(2%)	2	(1%)
2. Is your chief-of-staff or vice-chief-of-staff paid?						
Yes	1	(2%)	25	(30%)	26	(19%)
No	56	(98%)	58	(70%)	114	(81%)
If yes, by whom?						
Hospital	1		17		18	
Board of Trustees	0		1		1	
1/2 Hosp., 1/2 Medical Staff	0		3		3	
County	1		0		1	
3. Does your hospital have a medical director?						
Yes	16	(28%)	33	(40%)	49	(35%)
No	34	(60%)	46	(55%)	80	(57%)
If yes,						
Full time	4		22		26	
Part time	6		8		14	
MD	5		23		28	
Administrator	1		3		4	
Other	6		7		13	
4. Is there physician representation on the Board of Trustees?						
Yes	45	(79%)	71	(86%)	116	(83%)
No	9	(16%)	12	(14%)	21	(15%)
If yes, how many?						
1	27		27		54	
2	14		17		31	
3	2		12		14	
4	0		5		5	
5 & over	0		5		5	
How selected? (physician rep.)						
Appointed/Board of Trustees	9	(16%)	33	(40%)	42	(30%)
Chief-of-Staff	18	(32%)	9	(11%)	27	(19%)
Elected	7	(12%)	11	(13%)	18	(13%)
Other	6	(11%)	11	(13%)	17	(12%)

Continued on page 380

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5. Does your hospital have closed or open staff?						
Open	46	(80%)	72	(87%)	118	(85%)
Closed	6	(11%)	7	(8%)	13	(9%)
Both	2	(4%)	4	(5%)	6	(4%)
6. Does your hospital have mandatory insurance as a requisite for hospital privileges?						
Yes	25	(44%)	34	(41%)	59	(42%)
No	27	(47%)	44	(53%)	71	(50%)
Base limits:						
50,000	1		1		2	
100,000/300,000	18		13		31	
200,000/600,000	0		4		4	
No limits	4		5		9	
7. Does your Board of Trustees grant privileges to non-physicians?						
Yes	35	(61%)	61	(73%)	96	(69%)
No	17	(30%)	19	(23%)	36	(26%)
If yes, to whom?						
Dentists	18		20		38	
Podiatrists	12		16		28	
Psychologists	9		16		25	
Other allied health prof., i.e., social workers, nurse anesthetists, practitioners, physician assistants, clinicians, PhDs, therapists, oral surgeons, paramedics	18		32		49	
What mechanisms do you use? (non-physician privileges)						
Bylaws	7		4		11	
Credentialling	3		24		27	
Board of Trustees	2		5		7	
Medical Staff Committee	4		12		16	
Delineation	2		1		3	
8. Does your hospital have satellite clinics?						
Yes	5	(9%)	28	(33%)	33	(24%)
No	51	(89%)	55	(66%)	106	(76%)

The totals may not always add up to a sum of 57, 83 or 140 replies or 100% due to varying numbers of responses in some categories.

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______	025	Valproic Acid
______	026	Ethosuximide
______	027	Allopurinol
______	028	Oral Xanthine Derivatives
______	029	Thyroid Replacement
______	030	Metronidazole
______	031	Oral Clindamycin/Lincomycin
______	032	Oral Chloramphenicol
______	033	Levodopa/Carbidopa and Levodopa
______	034	Ergot Derivatives
______	035	Indomethacin
______	036	Phenylbutazone/ Oxyphenbutazone
______	037	Quinidine/Procainamide
______	038	Iron Supplements
______	039	Verapamil
______	040	Nifedipine

______	Total number of pads
x$.50	Per pad for postage and handling
$______	SUBTOTAL
$______	Residents of IL and NY, please add appropriate sales tax to SUBTOTAL.
$______	TOTAL PAYMENT (CHECK ENCLOSED)

Free blood tests are one of the attractions of the MSMS Annual Scientific Meeting exhibit hall. Annually about 75 pharmaceutical companies, medical supplies and services firms, publishing houses, armed services and other exhibitors display their products and aids for the attending Michigan physicians. Above, former Annual Scientific Meeting Chairman Robert F. Wilson, MD, takes advantage of the exhibit hall service.

Make your plans now!

The 1983 MSMS Annual Scientific Meeting is scheduled Nov. 15-17 at the Hyatt Regency Dearborn!

Watch for details
in coming issues
of *Michigan Medicine*
and *Medigram.*

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Bactrim™ DS
(trimethoprim and sulfamethoxazole/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications and Usage: For the treatment of urinary tract infections due to susceptible strains of the following organisms: *Escherichia coli, Klebsiella-Enterobacter, Proteus mirabilis, Proteus vulgaris, Proteus morganii.* It is recommended that initial episodes of uncomplicated urinary tract infections be treated with a single effective antibacterial agent rather than the combination. *Note:* The increasing frequency of resistant organisms limits the usefulness of all antibacterials, especially in these urinary tract infections.

For acute otitis media in children due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over other antimicrobials. To date, there are limited data on the safety of repeated use of Bactrim in children under two years of age. Bactrim is not indicated for prophylactic or prolonged administration in otitis media at any age.

For acute exacerbations of chronic bronchitis in adults due to susceptible strains of *Haemophilus influenzae* or *Streptococcus pneumoniae* when in physician's judgment it offers an advantage over a single antimicrobial agent.

For enteritis due to susceptible strains of *Shigella flexneri* and *Shigella sonnei* when antibacterial therapy is indicated.

Also for the treatment of documented *Pneumocystis carinii* pneumonitis.

Contraindications: Hypersensitivity to trimethoprim or sulfonamides; patients with documented megaloblastic anemia due to folate deficiency; pregnancy at term; nursing mothers because sulfonamides are excreted in human milk and may cause kernicterus; infants less than 2 months of age.

Warnings: BACTRIM SHOULD NOT BE USED TO TREAT STREPTOCOCCAL PHARYNGITIS. Clinical studies show that patients with group A β-hemolytic streptococcal tonsillopharyngitis have higher incidence of bacteriologic failure when treated with Bactrim than do those treated with penicillin. Deaths from hypersensitivity reactions, hepatocellular necrosis, agranulocytosis, aplastic anemia and other blood dyscrasias have been associated with sulfonamides. Experience with trimethoprim is much more limited but occasional interference with hematopoiesis has been reported as well as an increased incidence of thrombopenia with purpura in elderly patients on certain diuretics, primarily thiazides. Sore throat, fever, pallor, purpura or jaundice may be early signs of serious blood disorders. Frequent CBC's are recommended; therapy should be discontinued if a significantly reduced count of any formed blood element is noted.

Precautions: *General:* Use cautiously in patients with impaired renal or hepatic function, possible folate deficiency, severe allergy or bronchial asthma. In patients with glucose-6-phosphate dehydrogenase deficiency, hemolysis, frequently dose-related, may occur. During therapy, maintain adequate fluid intake and perform frequent urinalyses, with careful microscopic examination, and renal function tests, particularly where there is impaired renal function. Bactrim may prolong prothrombin time in those receiving warfarin; reassess coagulation time when administering Bactrim to these patients. *Pregnancy:* Teratogenic Effects: Pregnancy Category C. Because trimethoprim and sulfamethoxazole may interfere with folic acid metabolism, use during pregnancy only if potential benefits justify the potential risk to the fetus.

Adverse Reactions: All major reactions to sulfonamides and trimethoprim are included, even if not reported with Bactrim. *Blood dyscrasias:* Agranulocytosis, aplastic anemia, megaloblastic anemia, thrombopenia, leukopenia, hemolytic anemia, purpura, hypoprothrombinemia and methemoglobinemia. *Allergic reactions:* Erythema multiforme, Stevens-Johnson syndrome, generalized skin eruptions, epidermal necrolysis, urticaria, serum sickness, pruritus, exfoliative dermatitis, anaphylactoid reactions, periorbital edema, conjunctival and scleral injection, photosensitization, arthralgia and allergic myocarditis. *Gastrointestinal reactions:* Glossitis, stomatitis, nausea, emesis, abdominal pains, hepatitis, hepatocellular necrosis, diarrhea, pseudomembranous colitis and pancreatitis. *CNS reactions:* Headache, peripheral neuritis, mental depression, convulsions, ataxia, hallucinations, tinnitus, vertigo, insomnia, apathy, fatigue, muscle weakness and nervousness. *Miscellaneous reactions:* Drug fever, chills, toxic nephrosis with oliguria and anuria, periarteritis nodosa and L.E. phenomenon. Due to certain chemical similarities to some goitrogens, diuretics (acetazolamide, thiazides) and oral hypoglycemic agents, sulfonamides have caused rare instances of goiter production, diuresis and hypoglycemia in patients; cross-sensitivity with these agents may exist. In rats, long-term therapy with sulfonamides has produced thyroid malignancies.

Dosage: *Not recommended for infants less than two months of age.*

URINARY TRACT INFECTIONS AND SHIGELLOSIS IN ADULTS AND CHILDREN, AND ACUTE OTITIS MEDIA IN CHILDREN:

Adults: Usual adult dosage for urinary tract infections—1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 10-14 days. Use identical daily dosage for 5 days for shigellosis.

Children: Recommended dosage for children with urinary tract infections or acute otitis media—8 mg/kg trimethoprim and 40 mg/kg sulfamethoxazole per 24 hours, in two divided doses for 10 days. Use identical daily dosage for 5 days for shigellosis.

For patients with renal impairment: Use recommended dosage regimen when creatinine clearance is above 30 ml/min. If creatinine clearance is between 15 and 30 ml/min, use one-half the usual regimen. Bactrim is not recommended if creatinine clearance is below 15 ml/min.

ACUTE EXACERBATIONS OF CHRONIC BRONCHITIS IN ADULTS:

Usual adult dosage: 1 DS tablet (double strength), 2 tablets (single strength) or 4 teasp. (20 ml) b.i.d. for 14 days.

PNEUMOCYSTIS CARINII PNEUMONITIS:

Recommended dosage: 20 mg/kg trimethoprim and 100 mg/kg sulfamethoxazole per 24 hours in equal doses every 6 hours for 14 days. See complete product information for suggested children's dosage table.

Supplied: *Double Strength (DS) tablets,* each containing 160 mg trimethoprim and 800 mg sulfamethoxazole, bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 20. *Tablets,* each containing 80 mg trimethoprim and 400 mg sulfamethoxazole—bottles of 100 and 500; Tel-E-Dose® packages of 100; Prescription Paks of 40. *Pediatric Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per teaspoonful (5 ml); cherry flavored—bottles of 100 ml and 16 oz (1 pint). *Suspension,* containing 40 mg trimethoprim and 200 mg sulfamethoxazole per tea spoonful (5 ml); fruit-licorice flavored—bottles of 16 oz (1 pint).

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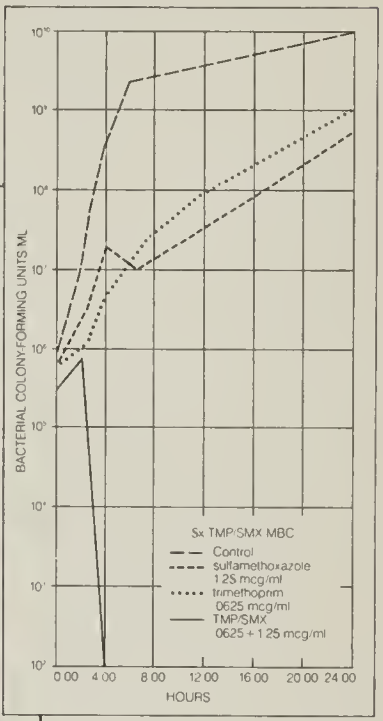
Percent of isolates of common uropathogens sensitive to BACTRIM and to other antimicrobials

	Escherichia coli	*Klebsiella pneumoniae*	*Proteus mirabilis*	*Proteus vulgaris*	*Proteus* sp.	*Enterobacter* sp.	*Enterobacter aerogenes*	*Enterobacter cloacae*
BACTRIM	**96%** 328,598	**89%** 63,551	**93%** 62,691	**84%** 4174	**91%** 4381	**88%** 1736	**96%** 7326	**92%** 11,856
ampicillin	72% 345,209	5% 65,466	85% 67,338	16% 4381	70% 4402	10% 1775	9% 7759	11% 12,091
cephalexin†	81% 343,339	85% 67,031	92% 67,027	16% 4398	80% 4365	22% 1834	13% 7571	12% 11,846
nitrofurantoin	97% 307,785	65% 61,162	7% 59,775	13% 3848	14% 3059	67% 1707	60% 7109	67% 10,830

†Analogous to cephalothin, the primary antibiotic disc used in testing.
Source: The Bacteriologic Report, BAC-DATA Medical Information Systems, Inc., Winter Series, 1981-82.
Numbers under percentages refer to the projected number of isolates tested.

RAPID *IN VITRO* DESTRUCTION OF *E. COLI**



Kill curve kinetics of Bactrim and its individual components against *E. coli in vitro.*[1]

The bactericidal action of Bactrim has been demonstrated *in vitro* on laboratory strains of *E. coli*[1,2] and on clinical isolates of *E. coli, Klebsiella-Enterobacter, Proteus mirabilis* and *Morganella morganii*[3]—the most common causative organisms of urinary tract infections.[4] More than 100 published studies attest to the efficacy of Bactrim in recurrent urinary tract infections due to these organisms.[5] In comparative studies with other antimicrobials, Bactrim has consistently demonstrated unsurpassed efficacy during therapy.[6-11]

Resistance to Bactrim develops more slowly than to either of its components alone *in vitro*.* Among urinary tract isolates, resistance has rarely emerged in susceptible strains.[5,12] Bactrim is contraindicated in pregnancy at term, during lactation, in infants less than two months old and in documented megaloblastic anemia due to folate deficiency.

Initial episodes of uncomplicated urinary infections should be treated with a single-agent antimicrobial.

Bactrim™ DS

(trimethoprim and sulfamethoxazole/Roche)

b.i.d. *for recurrent urinary tract infections*

**In vitro* data do not necessarily predict clinical results.

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See next page for references and a summary of product information.

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J-9043-4 July 1981

FINANCIAL PLANNING

Your retirement plan: Meeting top-heavy accrual and vesting requirements

By Dale E. Lamps
Grand Rapids

TEFRA gave the IRS a number of new ways to force retirement plans to increase benefits for rank and file employees. The new "top-heavy" rules are a prominent example.

When is a retirement plan top-heavy? Simply stated, the new rule says that if more than 60 percent of accrued benefits are for "key employees," the plan is top-heavy. Suffice it to say that virtually all retirement plans of medical practices will be top-heavy.

What do the new top-heavy rules do? First, they place new restrictions on benefits for key employees.

- The combined plan limitation fraction for participants covered by both a defined benefit and defined contribution plan is reduced from 1.25 to 1.00, as applied to the dollar limitations of IRC Section 415.
- Compensation is limited to $200,000 per year for purposes of calculating benefits or contributions.
- Distributions to "key employees" before age 59½ are subject to a special 10 percent additional tax.
- Distributions to "key employees" must commence by age 70½, whether or not the key employee continues working.

Second, they require more generous treatment of "non-key employees," including higher minimum vesting standards and new minimum accrual standards.

Two alternatives

What are these new vesting and accrual standards? How can they most efficiently be satisfied?

The vesting standards give you two alternatives:

1. Three years of service and age 25 required for participation; vesting full and immediate.
2. One year of service and age 25 required for participation; vesting scale as follows:

Years of Service	Vesting
Under 2	0%
2	20%
3	40%
4	60%
5	80%
6 or more	100%

Three-year eligibility with full vesting is usually more efficient.

Here is an example showing why. Assume a retirement program accrues $1 for each year of participation in the plan. The following projection shows the accumulated vested benefit for several years. Interest is ignored.

Years of Employment	1-Year Eligibility		3-Year Eligibility	
	Accrued	Vested	Accrued	Vested
1	0	0	0	0
2	$1	$ .20	0	0
3	$2	$ .80	0	0
4	$3	$1.80	$1	$1
5	$4	$3.20	$2	$2
6	$5	$5	$3	$3
7	$6	$6	$4	$4
8	$7	$7	$5	$5
9	$8	$8	$6	$6
10	$9	$9	$7	$7

This projection illustrates that three-year eligibility with 100 percent vesting actually provides a smaller vested benefit than the graded vesting scale. Thus, the cost of providing benefits to employees is reduced. The only exception to the above example would be for employees hired under age 23.

The *accrual requirements* in the law are defined separately for defined benefit and defined contribution plans.

For a *defined benefit* plan, the *minimum benefit accrual* is two percent of pay for each year of participation in the top-heavy plan, subject to a limit of 10 years, or 20 percent of pay.

For a *defined contribution* plan, the *minimum contribution* is three percent of pay. If the contribution on key employees is less than three percent, the minimum for non-key employees is decreased accordingly.

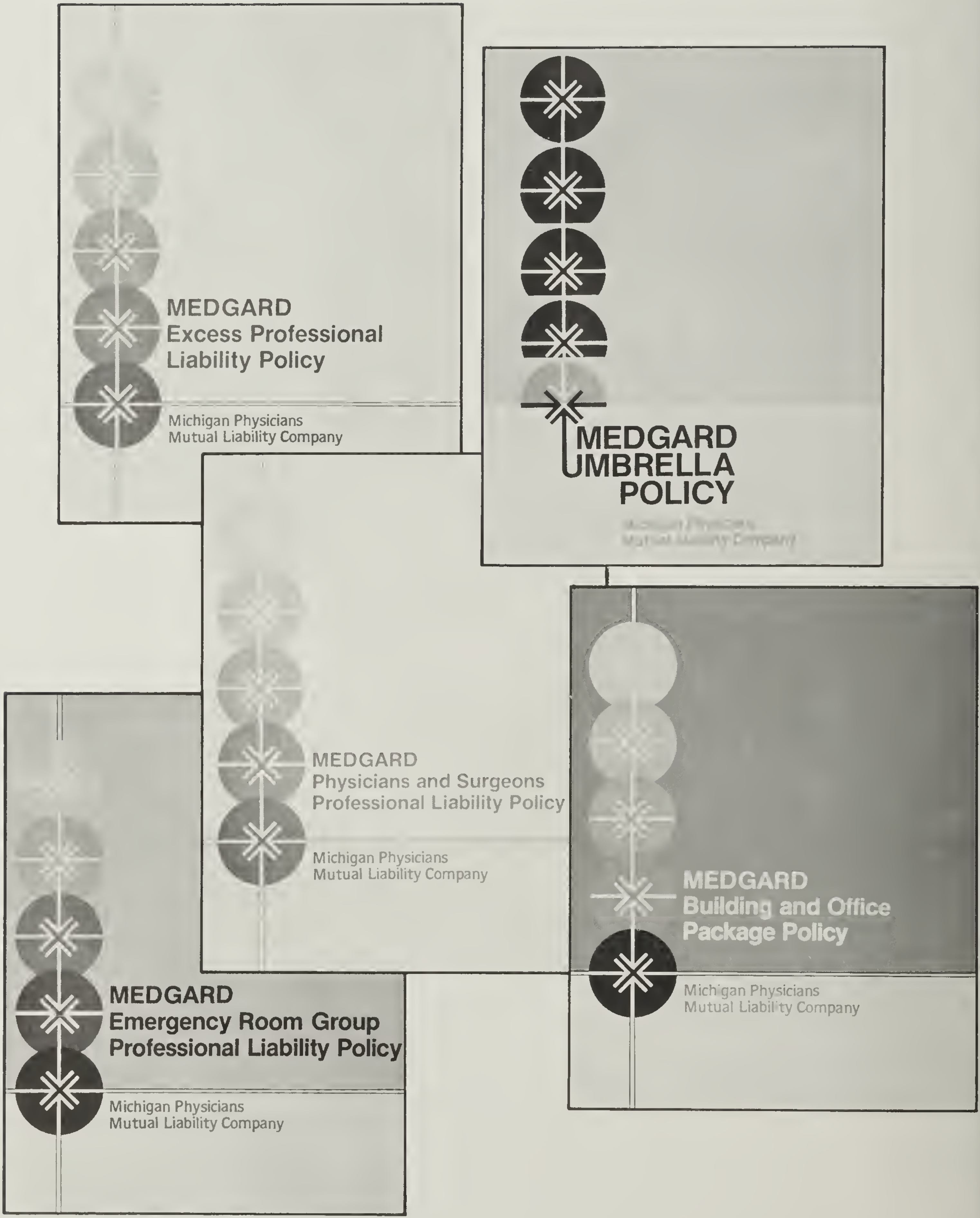
Five percent minimum

On originally studying the law, most pension practitioners concluded that a participant covered by *both* a defined benefit and defined contribution plan would be required to meet *either* the defined benefit minimum *or* the defined contribution minimum, (or some proportional combination) *but not both*. Now, however, the

Continued on page 388

Mr. Lamps is senior vice president with Watkins, Ross, Stanar and Lamps, the employee benefits consulting and actuarial firm headquartered in Grand Rapids. He is a fellow of the Society of Actuaries, a member of the Academy of Actuaries and author of many articles relating to the retirement plan field.

WHAT YOU SEE.



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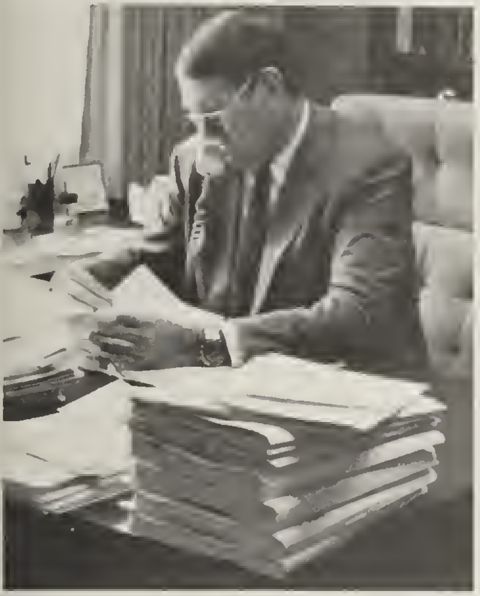

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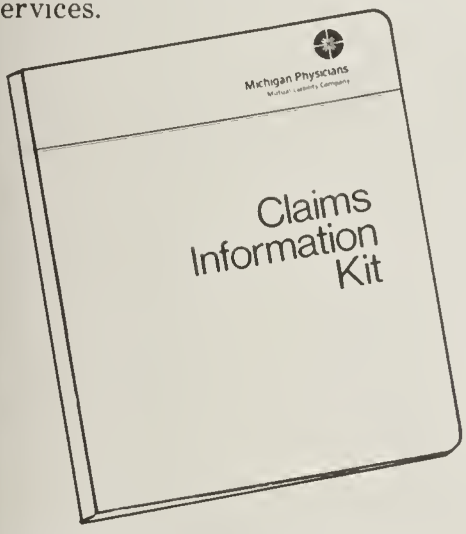
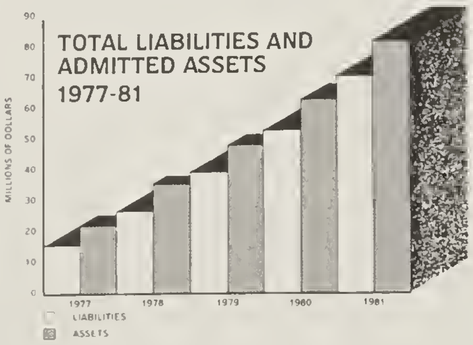


Communication. Our Closed Claim Questionnaire and the newly revised Claims Information Kit are examples of how we communicate with the physicians we insure. The MUTUAL MONITOR (our quarterly newsletter), risk management seminars, and special meetings at hospitals are other examples of how we are bringing information to the medical profession on a continuing basis.

Innovation. Our in-house computer system has streamlined company operations and enabled our staff to answer your questions about underwriting or claims immediately. This system is one of the most sophisticated in the nation and our data base of claims statistics pinpoints actuarial projections and provides research information for risk management programs.

Stability. Assets of over $88 million back our policies. That's more than $20,000 for each physician insured with us for primary, professional liability. Total surplus of $11.4 million is further evidence of our financial strength and stability. In other words, our policyholders have $3 of equity for every $4 of net premium that we write annually.



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IRS has issued proposed regulations that go beyond that early interpretation. The proposed regulations take the following positions where there is a combination of plans:

1. If the minimum accrual is to be met under the two percent defined benefit rule, the accrual requirements will be deemed satisfied.

2. If the minimum accrual is to be met under the defined contribution plan, the minimum will be five percent unless the plan sponsor can convince the IRS that a lower percentage is comparable to the two percent defined benefit minimum.

The proposed regulations point out that it will often be impractical to manage the comparability requirement. It thus appears that the defined contribution minimum has been established at five percent by IRS FIAT where a participant is also covered by a defined benefit plan without the minimum accrual. Nevertheless, you can be sure that practitioners, being inventive, will develop simple and effective ways of reducing the required contributions from the five percent level announced by the IRS. Consider for example, a schedule of contributions for non-key employees, based on age and service. Here are some sample ages showing how this schedule would appear.

Age	10 or Fewer Years*	More than 10 Years*
40 or less	3%	3%
45	4.2%	3%
50	5.9%	3%
55	8.3%	3%
60	12.6%	3%
65	16.3%	3%

*Years of participation in top-heavy plan.

As you can see from this, if enough of your non-key participants are under 50, your contribution ratio will be less than the five percent benchmark. If most non-key employees are over 50, the five percent safe harbor will be less costly.

In nearly all plans, it will still be less expensive to use the defined contribution minimums rather than defined benefit.

A final point on combination plans relates to the "floor-offset" approach. In a floor-offset program, the defined benefit accrual is reduced by the actuarial equivalent of the defined contribution accumulation. For most non-key employees, the defined contribution accumulation will fully offset the defined benefit accrual. Thus, the employee receives his defined contribution account, but nothing from the defined benefit plan.

The result is:

1. The benefit for key employees is based on the defined benefit plan.

2. Non-key employees generally receive their benefit from the defined contribution plan, with no benefits coming from the defined benefit plan.

In the future, most plans will require three years of service for participation with 100 percent vesting. Benefit accrual in defined benefit plans will be the projected pension benefit, multiplied by a fraction based on *years of participation in the plan* (not years of service with the employer, as presently provided by many plans).

Summary and conclusion

The majority of efficient, well-designed retirement programs in the future will have the following features:

1. Three-year eligibility.
2. 100 percent vesting.
3. Defined benefit accrual fraction based on years of participation, *not* years of service.
4. Defined benefit plans will often *not* provide top-heavy minimum accruals.
5. Top-heavy minimum accruals will be provided by a separate defined contribution plan covering non-key employees.
6. Defined contribution accruals will be used as an *offset* to defined benefit accruals.
7. The defined contribution rate will be five percent if enough non-key participants are over age 50.
8. The defined contribution rates will be based on a graded schedule if enough non-key participants are under age 50.

MULTIMODALITY THERAPY FOR HEAD & NECK CANCER

A Model for the 80's

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This program emphasizes the benefits and explores the future for cooperative therapeutic efforts in head and neck cancer. Prognostic, biological and pathological factors for patient management will be explored. Distinguished guests include: John Loré, M.D., Robert Wittes, M.D., James Marks, M.D., Robert Lindberg, M.D., David Schuller, M.D. and Monica Spaulding, M.D.

Sponsoring institutions include: Comprehensive Cancer Center of Metropolitan Detroit, Harper-Grace Hospitals, Wayne State University, Veterans Administration Hospital, and Bristol Laboratories.

For further information you may contact: Don Raga, Ph.D., Radiation Oncology Department, 4201 St. Antoine, Detroit, Michigan 48201. Phone: 313/494-9207.

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By Richard P. Horsch, MD
Livonia

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Runaway costs are an inevitable consequence of our medical reimbursement system that subsidizes patients' increased use of expensive, inefficient health care providers. At the same time, the system threatens and discourages patients' use of economical and efficient providers.

This obvious lesson has been learned the hard way by those who

---

Doctor Horsch, an anesthesiologist, is a member of the medical care cost control committees of both the Wayne County and Michigan State medical societies.

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pay for health care in the State of Michigan — Medicaid, insurance companies, and eventually consumers and taxpayers.

Reimbursement policies have directly encouraged hospitals to enter the routine health care market via a proliferation of expensive outpatient and satellite facilities and have encouraged patients to use these expensive facilities. As a result, the very survival of our most economical provider, the private practice office physician, is threatened and health care costs are spiralling.

Five times more

When a hospital facility (outpatient, ER or satellite) and a physician's office provide *identical patient care,* the hospital facilities *generate charges* at about five times the rate of the physician's office and are reimbursed at about four times the rate of the physician's office!

This fact was graphically illustrated by a study conducted by the Wayne County Medical Society.

For example, if a patient with a corneal abrasion and loose foreign body of the eye is treated with examination, irrigation, ointment and eye-patch and shield, the following charges are generated and the following reimbursement provided, depending upon where the service is provided:

Hospital Facility Fees*	
Walk-in Fee	$ 59.00
Eye Tray	34.00
Irrigation	32.00
(to hosp.)	
Ointment	16.00
Patch and Shield	18.00
Physician's Fee † (to ER Physician)	15.00
Total Charge	174.00
Paid by Insurance Co.	174.00°
Patient out-of-pocket expense	0

Doctor's Office or Clinic Fees	
Non-reimbursed charge	$ 10.00
Physician's Fee	15.00
Total Charge	25.00
Paid by Insurance Co.	15.00
Patient out-of-pocket expense	$ 10.00

The hospital gets the physician's fee, a facility fee and a materials fee. The doctors' clinics get only the physician's fee.

Blues reimbursement policies directly encourage the patient to use the expensive *hospital* provider where no out-of-pocket expense occurs, in spite of the fact that six patients can be treated in the doctor's clinic for the cost of treating one patient in the hospital facility. Such fiscal irresponsibility obviously contributes to the seemingly endless succession of Blues rate increase requests.

*** An average charge of three hospital facilities**

† Code 0001-BC-BS (Emergency first aid)

° The hospitals are actually reimbursed on a *cost basis,* which averages *about* 75 percent of charges. Charges X.75 = actual reimbursement

Continued on page 392

A
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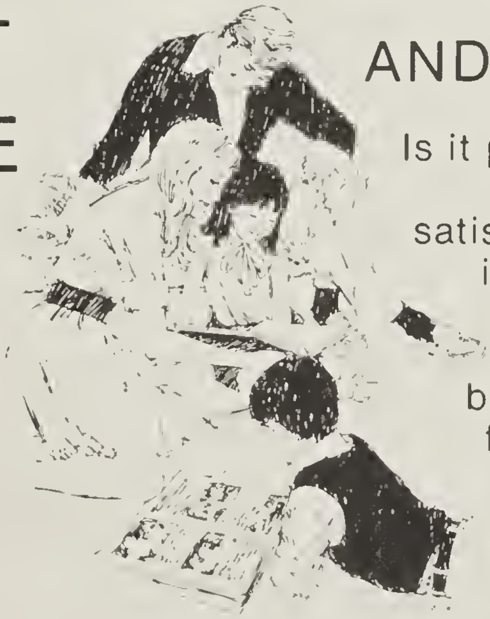

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PPSP's dramatic results

The same problem plagues Medicaid. Medicaid traditionally reimbursed hospital outpatient facilities on a "cost" basis, translating into a payment that averaged *over five times* that paid to a physician's office for rendering the same service.

The Department of Social Services routinely directed patients to these expensive hospital facilities, creating much of our Medicaid cost crisis. Physicians receive only a little more than *10%* of the total Medicaid budget!

However, at least in Wayne County, the Physician Primary Sponsor Plan (PPSP), promulgated by the MSMS and enacted by the Legislature, has finally eliminated this fiscal insanity. Under the PPSP, hospital outpatient and satellite facilities are reimbursed exactly as a physician's office is reimbursed — on a fee-for-service basis.

The results are dramatic! A recent *Detroit Free Press* article outlined the effects of the PPSP on Hutzel Hospital's new obstetric outpatient clinic. Payment for a prenatal visit dropped from $150 to $12. The Hospital finds itself in a financial crisis and is threatening to default on its bonds. However, the article also pointed out three other interesting facts — 1) the new clinic was built where no clinic was needed, 2) the clinic is expensive and inefficient with high overhead, and 3) an ample number of private sector physicians are willing to take care of these patients.

In Wayne County alone, *millions* of dollars are being saved every month by the PPSP, simply by equalizing payments between outpatient hospital facilities and doctor offices! For the first time, *equitable* competition exists. Without this equity of reimbursement, private office practice would quickly perish in the city of Detroit.

Demand equal competition

Hospitals and the Michigan Hospital Association are in the midst of a thus-far unsuccessful *massive* legislative and legal campaign to undo the PPSP and its provisions relating to reimbursement of outpatient and satellite facilities.

As a medical society, we must never back down from our support of the PPSP and the basic premise that equal service merits equal reimbursement. Cost control, quality patient care and the survival of office fee-for-service practice are at stake!

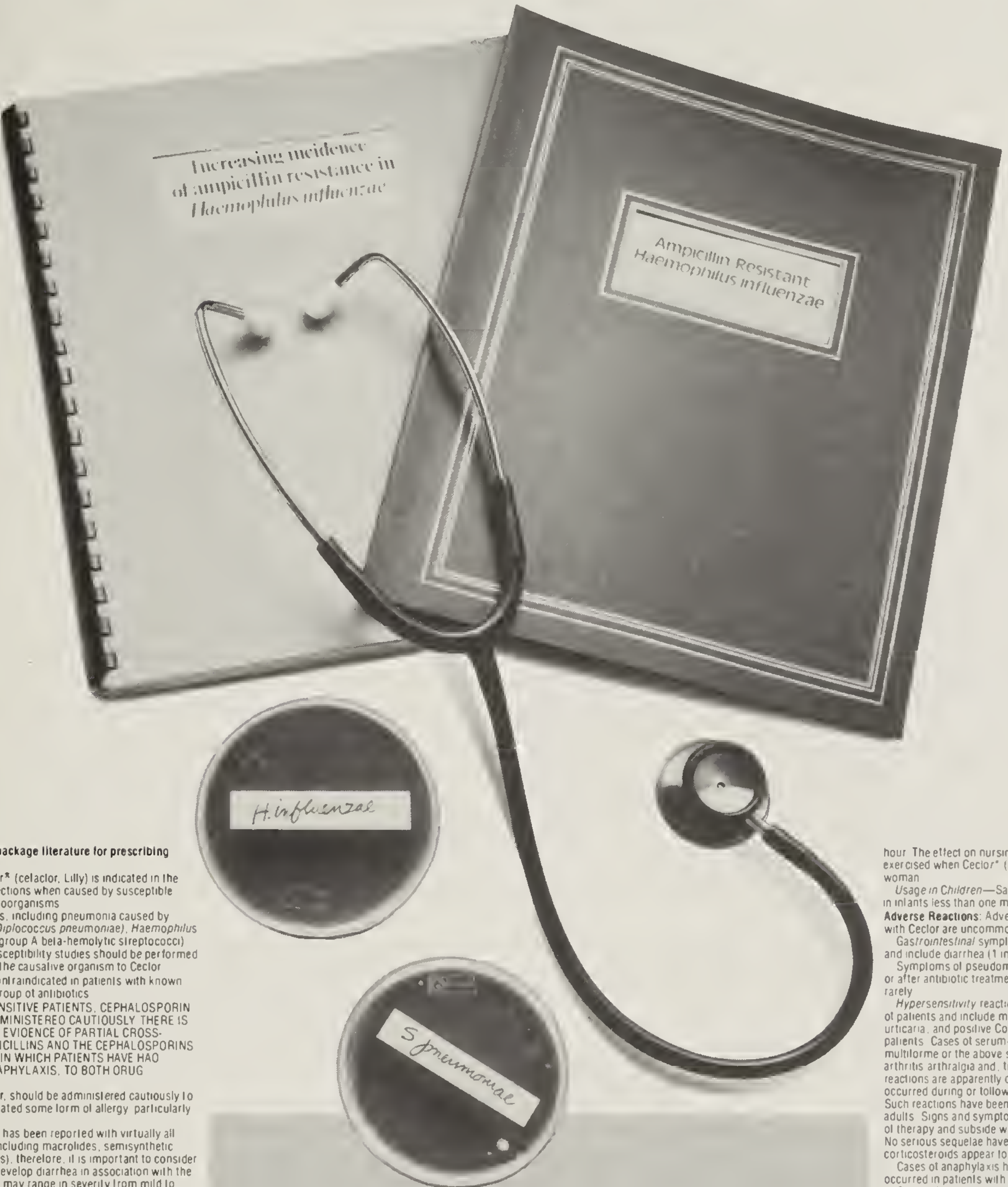
If fee-for-service practice does not survive and patients have no alternative but to use hospital facilities, the cost to the system will be astronomical.

As physicians, we have no right to limit our competition; however, we have every right to insist that this comptetition be an equitable competition where equal service receives equal payment.

In this system, *patients*, not insurance companies, would determine who survives and who does not survive, and improved patient care and cost control would be inevitable consequences of the competition.

"Exactly what is this complaint about your medical plan?"

An added complication... in the treatment of bacterial bronchitis*


Increasing incidence of ampicillin resistance in Haemophilus influenzae
Ampicillin Resistant Haemophilus influenzae
H. influenzae
S pneumoniae

Some ampicillin-resistant strains of Haemophilus influenzae—a recognized complication of bacterial bronchitis*—are sensitive to treatment with Ceclor.[1-6]

In clinical trials, patients with bacterial bronchitis due to susceptible strains of Streptococcus pneumoniae, H. influenzae, S. pyogenes (group A beta-hemolytic streptococci), or multiple organisms achieved a satisfactory clinical response with Ceclor.[7]

Ceclor®
cefaclor

Pulvules®, 250 and 500 mg

Brief Summary. Consult the package literature for prescribing information

Indications and Usage: Ceclor® (cefaclor, Lilly) is indicated in the treatment of the following infections when caused by susceptible strains of the designated microorganisms

Lower respiratory infections, including pneumonia caused by *Streptococcus pneumoniae (Diplococcus pneumoniae), Haemophilus influenzae*, and *S pyogenes* (group A beta-hemolytic streptococci)

Appropriate culture and susceptibility studies should be performed to determine susceptibility of the causative organism to Ceclor

Contraindication: Ceclor is contraindicated in patients with known allergy to the cephalosporin group of antibiotics

Warnings: IN PENICILLIN-SENSITIVE PATIENTS, CEPHALOSPORIN ANTIBIOTICS SHOULD BE ADMINISTERED CAUTIOUSLY THERE IS CLINICAL AND LABORATORY EVIDENCE OF PARTIAL CROSS-ALLERGENICITY OF THE PENICILLINS AND THE CEPHALOSPORINS AND THERE ARE INSTANCES IN WHICH PATIENTS HAVE HAD REACTIONS, INCLUDING ANAPHYLAXIS, TO BOTH DRUG CLASSES

Antibiotics, including Ceclor, should be administered cautiously to any patient who has demonstrated some form of allergy particularly to drugs

Pseudomembranous colitis has been reported with virtually all broad-spectrum antibiotics (including macrolides, semisynthetic penicillins, and cephalosporins), therefore, it is important to consider its diagnosis in patients who develop diarrhea in association with the use of antibiotics Such colitis may range in severity from mild to life-threatening

Treatment with broad-spectrum antibiotics alters the normal flora of the colon and may permit overgrowth of clostridia Studies indicate that a toxin produced by *Clostridium difficile* is one primary cause of antibiotic-associated colitis

Mild cases of pseudomembranous colitis usually respond to drug discontinuance alone In moderate to severe cases, management should include sigmoidoscopy appropriate bacteriologic studies, and fluid electrolyte, and protein supplementation When the colitis does not improve after the drug has been discontinued, or when it is severe oral vancomycin is the drug of choice for antibiotic-associated pseudomembranous colitis produced by *C difficile* Other causes of colitis should be ruled out

Precautions: *General Precautions*—If an allergic reaction to Ceclor occurs, the drug should be discontinued, and, if necessary the patient should be treated with appropriate agents, e g , pressor amines, antihistamines, or corticosteroids

Prolonged use of Ceclor may result in the overgrowth of nonsusceptible organisms Careful observation of the patient is essential If superinfection occurs during therapy, appropriate measures should be taken

Positive direct Coombs' tests have been reported during treatment with the cephalosporin antibiotics In hematologic studies or in transfusion cross-matching procedures when antiglobulin tests are performed on the minor side or in Coombs testing of newborns whose mothers have received cephalosporin antibiotics before parturition, it should be recognized that a positive Coombs' test may be due to the drug

Ceclor should be administered with caution in the presence of markedly impaired renal function Under such conditions, careful clinical observation and laboratory studies should be made because safe dosage may be lower than that usually recommended

As a result of administration of Ceclor, a false-positive reaction for glucose in the urine may occur This has been observed with Benedict's and Fehling's solutions and also with Clinitest® tablets but not with Tes-Tape® (Glucose Enzymatic Test Strip, USP, Lilly)

Broad-spectrum antibiotics should be prescribed with caution in individuals with a history of gastrointestinal disease, particularly colitis

Usage in Pregnancy—Pregnancy Category B—Reproduction studies have been performed in mice and rats at doses up to 12 times the human dose and in ferrets given three times the maximum human dose and have revealed no evidence of impaired fertility or harm to the fetus due to Ceclor There are, however, no adequate and well-controlled studies in pregnant women Because animal reproduction studies are not always predictive of human response this drug should be used during pregnancy only if clearly needed

Nursing Mothers—Small amounts of Ceclor have been detected in mother's milk following administration of single 500-mg doses Average levels were 0 18, 0 20, 0 21, and 0 16 mcg/ml at two, three four, and five hours respectively Trace amounts were detected at one hour The effect on nursing infants is not known Caution should be exercised when Ceclor® (cefaclor Lilly) is administered to a nursing woman

Usage in Children—Safety and effectiveness of this product for use in infants less than one month of age have not been established

Adverse Reactions: Adverse effects considered related to therapy with Ceclor are uncommon and are listed below

Gastrointestinal symptoms occur in about 2 5 percent of patients and include diarrhea (1 in 70)

Symptoms of pseudomembranous colitis may appear either during or after antibiotic treatment Nausea and vomiting have been reported rarely

Hypersensitivity reactions have been reported in about 1 5 percent of patients and include morbilliform eruptions (1 in 100) Pruritus, urticaria, and positive Coombs tests each occur in less than 1 in 200 patients Cases of serum-sickness-like reactions (erythema multiforme or the above skin manifestations accompanied by arthritis arthralgia and, frequently fever) have been reported These reactions are apparently due to hypersensitivity and have usually occurred during or following a second course of therapy with Ceclor Such reactions have been reported more frequently in children than in adults Signs and symptoms usually occur a few days after initiation of therapy and subside within a few days after cessation of therapy No serious sequelae have been reported Antihistamines and corticosteroids appear to enhance resolution of the syndrome

Cases of anaphylaxis have been reported half of which have occurred in patients with a history of penicillin allergy

Other effects considered related to therapy included eosinophilia (1 in 50 patients) and genital pruritus or vaginitis (less than 1 in 100 patients)

Causal Relationship Uncertain—Transitory abnormalities in clinical laboratory test results have been reported Although they were of uncertain etiology, they are listed below to serve as alerting information for the physician

Hepatic—Slight elevations of SGOT, SGPT, or alkaline phosphatase values (1 in 40)

Hematopoietic—Transient fluctuations in leukocyte count predominantly lymphocytosis occurring in infants and young children (1 in 40)

Renal—Slight elevations in BUN or serum creatinine (less than 1 in 500) or abnormal urinalysis (less than 1 in 200)

[061782R]

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*Many authorities attribute acute infectious exacerbation of chronic bronchitis to either *S pneumoniae* or *H influenzae* [8]

Note Ceclor is contraindicated in patients with known allergy to the cephalosporins and should be given cautiously to penicillin-allergic patients

Penicillin is the usual drug of choice in the treatment and prevention of streptococcal infections, including the prophylaxis of rheumatic fever See prescribing information

References

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8 Principles and Practice of Infectious Diseases (edited by G L Mandell, R G Douglas, Jr , and J E Bennett), p 487 New York John Wiley & Sons, 1979

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Additional information available to the profession on request from Eli Lilly and Company, Indianapolis, Indiana 46285

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NEWS

By Sheri W. Greenhoe
East Lansing

Beninson

Combs

Krull

Peterson

William J. Fuller, MD, Grand Rapids, was featured in the April 13 *Grand Rapids Press* as part of a series recognizing the accomplishments and leadership of West Michigan senior citizens. The article traced Doctor Fuller's involvement in medicine back through his days as a medical student and Army surgeon. . . . **Ricardo E. Duque, MD,** post-doctoral fellow in immunopathology at U-M, recently won the American Association of Pathologists' Experimental Pathologist in Training Award. He is involved in research into white blood cell response to stimuli. . . . Three prominent Henry Ford Hospital staff members recently retired after more than 40 years of service each. They are: **Dwight Ensign, MD,** founder of the hospital's Rheumatology Division; **C. Paul Hodgkinson, MD,** former chairman of Gynecology-Obstetrics; and **Joseph Shaffer, MD,** founder and former head of the Allergy Division. . . . **Henry M. Domzalski, MD,** president of Wayne County Medical Society, was among 10 county and state medical society representatives invited to the White House for a meeting with President Reagan recently, to discuss the voluntary efforts to provide health care to the unemployed. Also attending the meeting was **John Coury, MD,** Port Huron, vice president of the AMA Board of Trustees. . . . **Rhoda Powsner, MD, JD,** Ann Arbor, will address the Michigan Association of the Professions at its annual Congress in August. Her topic will be "Bridging the Gap between the Professions." . . . **Louis R. Zako, MD,** new MSMS president-elect, also is new president of the Michigan Health Council, a voluntary health education organization. . . . **Larry Braak, MD,** Marquette, recently was named medical director of the Youth Substance Abuse Treatment Unit to be opened soon at Marquette General Hospital. . . . New members of the Michigan Hospital Association's Committee on Hospital Governance, which serves to assist community leaders in their roles as hospital trustees, are: **Robert Clowater, MD,** Saginaw; and **Philip Stott, MD,** Kalamazoo. . . . Completing his year as president of the Society of Gynecologic Surgeons, **George W. Morley, MD,** Ann Arbor, presided over the society's recent annual meeting in New Orleans. . . . **Arthur S. Elstein, PhD,** professor of medical education research and development in

Continued on page 396

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☐ Post Graduate Medical Resident	$300	**TOTAL** ______________	

MSU's College of Human Medicine, has been appointed a member-at-large of the National Board of Medical Examiners for a four year term. . . . Two pathologists with a combined total of 60 years service in the Benton Harbor/St. Joseph area were honored at a retirement tea recently at Mercy Hospital. They are: **William H. Benner, MD,** and **Richard E. Lininger, MD.** . . . **Joseph E. Cooper, MD,** Bangor, was the 1983 VanBuren County Honorary Easter Seal Telethon Chairman. Doctor Cooper suffered a stroke four years ago which left him unable to speak or move, but he has now recovered his speech and is working toward the day when he will be able to walk again. . . . **Roy T. Bergman, MD,** Escanaba, has been named to the USA Olympic Team medical staff for the Summer '84 Olympic Games to be held in Los Angeles. In addition, Doctor Bergman will serve as head physician for the 1983 USA Pan American Game Team in Venezuela this August. . . . **Arnold R. Axelrod, MD,** Detroit, has been named a Distinguished Alumni of the Wayne State University School of Medicine. He is a nationally known internist and hematologist, and was the first Detroit-area physician to practice hematology as a subspecialty. **Hermann Pinkus, MD,** Detroit, was presented with the Lawrence M. Weiner Award for outstanding achievement of a non-alumnus, for his work in dermatology and cancer. He is past president of several state and national medical organizations. . . . **James Tobin, MD,** Ishpeming, was elected to the Ishpeming City Council in April. . . . **Edwin P. Peterson, MD,** Ann Arbor, was installed as president of the American Fertility Society at the 39th Annual Meeting in San Fransicso. He has been active in that society since 1970, serving in several offices. . . . MSMS President **Donald Crandall, MD,** Muskegon, recently lectured at his alma mater, Albion College, on the value of his liberal arts education to his success as a physician. Doctor Crandall said it helped to "temper the rigidity of a highly technical future." . . . **Boy Frame, MD,** Detroit, was co-chairman of Henry Ford Hospital's Third International Symposium on Bone and Mineral Metabolism, which was held in May. The symposium drew registrants from around the world. . . . **Julius V. Combs, MD,** Detroit, was installed as president of the Wayne State University School of Medicine Alumni Association at the organization's Medical Alumni Reunion Day recently. A graduate of the class of 1958, Doctor Combs holds positions in several professional organizations. . . . **Joseph Beninson, MD,** Detroit, has been elected president of the International Society of Lymphology — North American Chapter. He had been vice president for the past two years, and is founder of the organization. . . . **Joseph C. Cerny, MD,** Henry Ford Hospital chairman of Urology, is president of the Reed Nesbit Urology Society, 150 urologists who trained with Doctor Nesbit or at the University of Michigan. . . . **Pedro Cortes, MD,** Detroit, was recently elected to the Central Society for Clinical Research . . . Member of the Board of Directors of the American Diabetes Association-Michigan Affiliate is **David Fachnie, MD,** Detroit. . . . Senior editor of *Vascular Medicine*, a new clinical journal, is **Gordon Folger, MD,** director of Henry Ford Hospital's Clinic for Children with Cardiovascular Disease. . . . **Dorothy Kahkonen, MD,** Detroit, was recently honored by the American Diabetes Association-Michigan Affiliate, of which she has been president for two years, for "outstanding leadership and excellent contributions." She is on the board of directors of the national organization. . . . Detroit physician **Edward A. Krull, MD,** has been elected to the Board of Directors of the American Academy of Dermatology, the main policy-making group and post-graduate education source for dermatologists in the US. . . . Along with a Nobel Prize winner and the AMA president, **Clarence S. Livingood, MD,** Detroit, was awarded an honorary Doctor of Science degree from his alma mater, Ursinus College in Pennsylvania. . . . New chairman of the Orthopaedic Section of the Pediatric Academy, a national group including pediatric orthopaedic specialists, is **Dennis Lyne, MD,** Detroit. . . . **Donald J. Magilligan, Jr., MD,** Detroit, has been elected to the Executive Committee of the Council on Cardiovascular Surgery of the American Heart Association. . . . New president-elect of the Michigan Chapter, American College of Emergency Physicians is **Richard M. Nowak, MD,** Detroit. . . . Recipient of the H.P. Smith Memorial Award, presented by the American Society of Clinical Pathologists, is **John W. Rebuck, MD,** Detroit. He was cited for his "contributions to pathology and hematology and a long, distinguished career devoted to scientific research." . . . **Paul D. Stein, MD,** Detroit, has been elected president of the Laennec Society, a section of the Council of Clinical Cardiology in the American Heart Association. . . . **Dwight Ensign, MD,** founder of the Section of Rheumatology at Henry Ford Hospital, retired at the end of last year. Having come to the hospital in 1924 as a resident, he was the longest-term staff member still practicing — after 58 years. . . . **Robert J. Priest, MD,** former chief of gastroenterology at Henry Ford Hospital, was recently honored when the Gastroenterology Library was dedicated in his name. He had served as division head for 16 years. . . . **Lester Weiss, MD,** Detroit, has been appointed to the Steering Committee,

Continued on page 398

MEDICAL DIRECTOR

Hospice of Lansing, a non-profit homecare program for persons with a life expectancy of six months or less is now seeking a quarter-time Medical Director.

Hospice of Lansing has provided care to over 150 patients and families since April 1981. Commencing this spring, Hospice has the first specialized hospice program for children in Michigan.

The Medical Director is a licensed physician responsible for all medical aspects of the program, including consultation with attending physicians, supervision of medical care rendered to patients, and coordinating an on-call schedule of community physicians.

Desirable skills include expertise in palliative care, orientation to Hospice principles, preferences for working in an interdisciplinary team setting and for working cooperatively with area physicians. Pediatric experience an advantage. If interested, submit your credentials and resumes to: **HOSPICE OF LANSING, 631 South Waverly Road, Lansing, MI 48917 (517) 321-5936.**

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NEWS/*Continued*

Division of Services to Crippled Children, State of Michigan. . . . Five specialists from Henry Ford Hospital have been awarded a four-year, $340,000 federal grant to continue studies of a rare type of detectable hereditary cancer — medullary cancer of the thyroid gland. They are: **Robert A. Norum, MD; Angelos A. Kambouris, MD; Gary B. Talpos, MD; Daniel L. Van Dyke, PhD;** and **Charles Jackson, MD,** principal investigator.

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CATEGORY I COURSES

***Michigan Medicine* each month carries a list of opportunities in Michigan for doctors of medicine to obtain Category I credit toward meeting the requirements of Michigan law. Sponsors of Category I programs and courses in Michigan are invited to submit information for the monthly calendar.**

Each listing below, of programs that carry at least 3 hours of Category I credit, indicates a contact person, so the physician can obtain details. Physicians with questions about accredited programs may phone MSMS Headquarters, (517)337-1351.

Date: June 19-24, Nineteenth Annual Northern Michigan Summer Conference. Location: Hilton Shanty Creek, Bellaire. **Sponsor:** U-M Office of CME, Dept. of Postgraduate Medicine and Health Professions Education. **Cost:** $395. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 20 hours of Category I Credit.

Date: June 21-23, Real-time Ultrasound in Obstetrics and Gynecology. Location: Towsley Center for CME, Ann Arbor. **Sponsor:** Postgraduate Medicine and Health Professions Education, University of Michigan. **Cost:** $575. **Contact:** Office of CME, Department of Postgraduate Medicine and Health Professions Education, The Towsley Center, U-M, Ann Arbor 48109 (313) 763-1400. **Approved for:** 22.5 hours of Category I Credit.

Date: June 24-26, Urology Outing. Location: St. Clair Inn, St. Clair. **Sponsor:** Wayne State University School of Medicine, Office of CME. **Cost:** $160. **Contact:** WSU School of Medicine, Division of CME, 4201 St. Antoine, 4H University Health Center, Detroit 48201. **Approved for:** 12 hours of Category I Credit.

Date: July 10-13, You Could Go To Court. Location: Grand Hotel, Mackinac Island. **Sponsor:** Department of Postgraduate Medicine and Health Professions Education, and University of Michigan Hospitals. **For:** Physicians, lawyers and other professionals desiring an update on medicolegal issues. **Cost:** $245; $115 one-day fee. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 11 hours of Category I Credit.

Date: July 10-13, Intermediate Course on Craniosacral Technique. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: July 13, Second Summer Conference: Dermatology for the Practitioner. Location: Towsley Center, Ann Arbor. **Sponsor:** Office of CME, Department of Postgraduate Medicine and Health Professions Education, U-M. **For:** Family and general practitioners, internists, pediatricians, and other interested health care professionals. **Cost:** $115. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 8 hours of Category I Credit.

Date: July 18-19, Developing, Marketing, and Managing Conferences: Making It In Tough Times. Location: The Towsley Center, Ann Arbor. **Sponsor:** The University of Michigan Medical School, The Office of Continuing Medical Education, Department of Postgraduate Medicine and Health Professions Education. **For:** Those who will develop/manage conferences and need to know how to do it more effectively and economically, whether for universities, hospitals, professional societies, businesses, or hotels. **Cost:** $345. **Contact:** Office of Continuing Medical Education, The Towsley Center, University of Michigan Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 12.5 hours of Category I Credit.

Date: July 21-22, Clinical Dietitian's Update. Location: Towsley Center, Ann Arbor. **Sponsor:** Office of CME, Department of Postgraduate Medicine and Health Professions Education and U-M Hospitals Nutrition Services, Department of Dietetics. **Cost:** $135. **Contact:** Office of CME, Towsley Center, U-M Medical School, Ann Arbor 48109, (313) 763-1400. **Approved for:** 13 hours of Category I Credit.

July 28-29, Coller Penberthy Thirlby Medical Conference. Location: Park Place Hotel, Traverse City. **Sponsor:** Munson Medical Center. **Contact:** Norma Powers, Coordinator of Medical Education, Munson Medical Center, 6th & Madison Sts., Traverse City 49684 (616) 947-6140, Ext. 146. **Approved for:** 9 hours of Category I Credit.

Date: August 15-19, Tutorial on Direct Action Thrusting. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: September 12-16, Basic Muscle Energy Tutorial. Location: Kellogg Center (MSU), East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

Date: Sept. 29-Oct. 1, New Perspectives in Cardiac Imaging. Location: Hyatt Regency, Dearborn. **Sponsor:** Professional Education Committee of the Michigan Heart Association, and Council on Clinical Cardiology of the American Heart Association. **Contact:** Eleanor D. Peterson, RN, Program Consultant, Michigan Heart Association, 16310 W. 12 Mile Road, PO Box 160-LV, Lathrup Village 48076, (313) 557-9500. **Approved for:** 17 hours of Category I Credit.

Date: Sept. 29-Oct. 2, Sixth Annual Course in Diagnostic Ultrasound. Location: The Towsley Center, U-M Medical School, Ann Arbor. **Sponsor:** U-M Office of Continuing Medical Education. **Contact:** Office of Continuing Medical Education, Towsley Center Box 057, University of Michigan Medical School, Ann Arbor, 48109, (313) 763-1400. **Approved for:** 24 hours of Category I Credit.

Date: Sept. 30-Oct. 2, Tutorial on Myofascial Release Technique. Location: MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 24 hours of Category I Credit.

Date: Oct. 3-7, Advanced **Muscle Energy Tutorial (above diaphragm). Location:** MSU Kellogg Center, East Lansing. **Sponsor:** MSU College of Osteopathic Medicine. **Contact:** Sandra Kilbourn, MA, A329 E. Fee, MSU-College of Osteopathic Medicine, East Lansing 48824, (517) 353-8822. **Approved for:** 40 hours of Category I Credit.

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SB 224—the omnibus medical malpractice liability insurance bill of 1983, was introduced May 2 with a flourish by Sen. Patrick McCollough (D-Dearborn). Sen. McCollough called a news conference attended by a dozen TV, radio, and newspaper reporters at which he described the intent of the legislation and passed out copies of the bill. The five-part bill is designed to prevent the cost of medical malpractice premiums from becoming prohibitive, and thus to stave off another professional liability insurance crisis like that of the 1970s. At the conference Sen. McCollough was flanked by MSMS President Donald K. Crandall, MD, left, and President William G. Anderson, DO, of the Michigan Association of Osteopathic Physicians and Surgeons. Both MSMS and MAOPS strongly support the bill. At far left at head of table is Blue Cross Blue Shield of Michigan Medical Director Armen Shekerjian, MD. BCBSM also supports SB 224.

MSMS supports new liability insurance bill

A Lansing television reporter at the professional liability legislation news conference took advantage of the occasion to ask MSMS President Crandall questions on health care costs, fraud and abuse.

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DEATHS

Charles W. Cory, MD
Saginaw

Charles W. Cory, MD, lifelong Saginaw resident, died April 2. He was 74. Doctor Cory received his premed and medical education from the University of Michigan, where he earned his MD in 1936. He had been medical director at Baig Rehabilitational Service of Saginaw, and was former chief of pediatrics at St. Luke's Hospital. He was affiliated with Saginaw General and St. Mary's Hospitals also, and had been chief of staff at a children's home at one time. Doctor Cory had been a major in the US Air Force in World War II.

Fridolph E. Erlandson, MD
Ludington

Fridolph E. Erlandson, MD, Ludington general surgeon, died March 12 at the age of 61. He was chief of staff at Memorial Medical Center, and had maintained an active practice through December of last year. Doctor Erlandson was a 1946 graduate of Western Reserve University School of Medicine. He served his internship at St. Luke's Hospital of Cleveland, and his residency with the US Marine hospitals in Cleveland and New York City.

Ernest C. Hansen, MD
Manistee

Ernest C. Hansen, MD, Manistee, died March 17. He was 81. Doctor Hansen, a 1926 graduate of the U-M Medical School, was a past president of Manistee County Medical Society, and a former MSMS delegate. He practiced in Manistee for more than 45 years, and spent much of that time as the community's health officer. Doctor Hansen had been chief of staff at Mercy Community and West Shore hospitals, and had been a Lt. Commander in the Navy Medical Corps during WWII.

Archie E. Humphrey, MD
Marshall

Archie E. Humphrey, MD, Marshall general practitioner, died March 26. He was 84. Doctor Humphrey was a school teacher before earning his MD in 1930 from the University of Michigan. He then interned at Henry Ford Hospital. He was a Selective Service examining physician during WWII, for which he received a presidential citation. In 1968 he was honored by the Calhoun County Social Services Board for his work with the area's needy, ill and elderly. Doctor Humphrey retired from active practice in 1975, and in 1980 received an MSMS 50-year pin.

Ernest T. Marshall, Jr., MD
Detroit

Ernest T. Marshall, Jr., MD, Detroit, died April 16. He was 45. Doctor Marshall had been an ophthalmologist practicing in Southfield, and was affiliated with Metropolitan Hospital of Detroit. He earned his medical degree in 1963 from Wayne State University School of Medicine. He was a member of the American Board of Ophthalmology, the American Academy of Ophthalmology and Otolaryngology, and the American College of Surgeons. He served in the US Navy Medical Corps from 1967 until 1969.

Ralph Ten Have, MD
Grand Haven

Ralph Ten Have, MD, Grand Haven, died March 17. He was 86. Doctor Ten Have was a 1924 graduate of the U-M Medical School, and did his internship at Detroit Receiving Hospital. Doctor Ten Have, upon his retirement in 1963, held the state record for longevity with a single county as Ottawa County Health Officer. He held that post for more than 32 years. In 1963 he was named "Health Officer of the Year." Doctor Ten Have had a lifelong interest in mental health, and served in the US Navy from 1917 until 1920.

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which interfere with
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If so, please contact your MSMS Program to Assist Impaired Physicians through Katie Brewbaker at MSMS headquarters, (517) 337-1351.

AMWA to stage annual meeting November 9-13 in Dearborn

The American Medical Women's Association will hold its 1983 Annual Meeting November 9 through 13, 1983, at the Hyatt Regency, Dearborn. The conference will immediately precede the 1983 MSMS Annual Scientific Meeting at the same location.

AMWA's 68th Annual Meeting combines a continuing medical education session, programs dedicated to women's personal and professional advancement as physicians, election of AMWA officers and AMWA Bylaws and Resolutions hearings in a week-long program.

Meeting highlights include:

- Keynote speakers on the meeting's CME topic, "Aging and the Art of Medicine: Geriatrics — A Woman's Issue." Today's pioneers in the rapidly changing field of geriatric medicine will speak and conduct workshops on November 9, 10 and 12.
- Professional Resources Research Center workshops and panel discussions on promotion and tenure in medical academia and institutions. These, plus basic leadership skills workshops are offered throughout the week.
- Career development, financial management, legislative issues and AMWA branch development workshops are also being presented throughout the week.
- Receptions, "Take a Student to Lunch," specialty breakfasts, networking lunch and many other social opportunities to meet other women physicians and medical students. Participate in, take advantage of the expanding AMWA network of support for women in medicine.

Registration materials and a complete annual meeting program will be available in early summer. To make sure you receive further information and a registration form, contact AMWA National Office, 465 Grand Street, New York, NY 10002, Attention: Meeting Coordinator.

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Positions Open

INVASIVE CARDIOLOGIST, hospital rounds duties and some diagnostic testing. Mid-Atlantic States area. Abilities to do streptokinase and/or angioplasty desirable. Salary and bonus. Respond with C-V to Box 44, *Michigan Medicine,* 120 W. Saginaw, East Lansing, MI 48823.

PHYSICIAN (MD or DO) NEEDED to work with owner-operator of large, established family practice. Deluxe new building has lab, X-ray, sports medicine facility and complete diagnostic equipment. Clinic's holistic approach combines the best of traditional medicine with the most effective contemporary modalities, including laser surgery, chelation therapy, etc. Physicians assistant and certified athletic trainers already on staff. Added services and expanded patient load necessitate additional physician. Remuneration on percentage basis with unlimited potential. Contact: Grant R. Born, DO, Born Preventive Health Care Clinic and Sports Medicine/Rehabilitation Center, 2786 44th St., SE, Grand Rapids, MI 49508.

FAMILY PHYSICIANS — Unique opportunity for BC/BE family practice physician to join prepaid group practice in Kansas City. To staff and develop a family practice facility 15 minutes from established multi-specialty group practice. Facility will include laboratory, x-ray, and pharmacy. Attractive salary structure and liberal fringes. Starting salary based on experience. Recruitment and relocation expenses covered. Send CV to Michael R. Soper, MD, 6801 E. 117th Street, Kansas City, Missouri 64134, or call (816) 765-6200.

CLINICAL PSYCHIATRISTS WANTED — Stable, highly respected organization which limits its activities to evaluation medicine is in need of American Board Certified psychiatrists, on a full or part-time basis, in southeast Michigan (Detroit, Flint, Bloomfield). This is an excellent opportunity for those psychiatrists who wish to eliminate the day-to-day problems of treatment practice, or for those who seek part-time forensic work as a supplement to treatment income. Work schedules revolve around individual work load requirements and physician-determined availability. Please forward *Curriculum Vitae* to J.C. Day, MD, 14295 East Seven Mile Road, Detroit, Michigan 48205 or call collect (313) 527-4620.

CARDIOLOGISTS — To join well-established Cardiovascular referral practice in Pennsylvania. Abilities in management of hospital patients, full invasive and noninvasive diagnostic testing required. Excellent beginning salary and fringe benefits. Opportunity to become full member of corporation at 18-24 months. Respond with CV to Box 43, *Michigan Medicine,* 120 W. Saginaw, East Lansing, MI 48823.

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TEXAS NEEDS DOCTORS. Immediate openings for family physicians, emer. room, gen. surgeon, internists, neurologist, ob/gyn, ophthalmologist, orthopods, ent, and pedis in Dallas and other cities/towns throughout the state. Group or solo opportunities with generous guarantees where they need additional physicians, and other physicians will give you referrals. Vacancies available because of retirement. No state income or corporate taxes in Texas. No fee. Contact Texas Doctors Group, Box 177, Austin, Texas 78767 (512/476-7129).

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PRESIDENT/*Continued*

that directly contribute to the care of an individual patient.

The advent of DRGs will significantly affect the financial integrity of our hospitals, and place a strain on hospital-medical staff relations. It will be imperative that each of us works with our hospitals during this transition to DRGs, to help the hospitals become more cost effective.

It will be important for our hospitals to work with their medical staffs while physicians learn to deliver quality medical care under this new system. The future of our hospital staff privileges may well depend on our ability as individual physicians to deliver cost effective medical care within the guidelines of DRGs.

The House of Representatives, in passing on the new rules for DRGs earlier this year, directed the secretary of Health and Human Services to develop a prospective reimbursement system for physicians. Thus, the birth of TEFRA II. We can expect the surfacing of RCEs; that is, "reasonable compensation equivalents." The federal government has already established what it feels are reasonable salary levels for every type of physician in every location of the country. It is not hard to see the impact of this on our profession.

Deregulation

All of this is called deregulation and a move toward increasing competition, although it is sometimes hard to see the deregulation from where we stand. There will be, nonetheless, a definite move to increasing competition with market forces playing a greater role in the delivery of health care.

We all are familiar with the federally financed GMENAC study of 1980. With a surplus of doctors projected for the latter part of this decade, with increasing competition from and amongst HMOs and PPOs, and with the advent of new types of delivery systems, it is not difficult to see the competition of the future. Adding to this, are a greater number of nurse practitioners, midwives, and other paramedical personnel seeking their share of the medical care market. You also will see an expansion of the hospice movement, wellness centers, wholistic health care programs, and self-help programs.

Now you can begin to see the storm on the horizon.

Next month: How MSMS is preparing its members for gathering health-care storms.

formation. Captain Bob Cook, 3255 S. Lakeshore, Ludington, MI 49431. (616) 845-7620.

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Bill O'Malley

"She's the new nurse in the children's ward."

U.P. annual meeting June 23-25

The Dickinson-Iron County Medical Society will host the 1983 Upper Peninsula Medical Society Educational Meeting June 23-25 in Iron Mountain.

A scientific program is planned, consisting of approximately 12 hours of education over two days with related recreational and spouses' activities.

The program will extend from Thursday evening, June 23, through Sunday, June 25. It will be broadly based, emphasizing new trends and therapies in internal medicine, obstetrics-pediatrics, and surgery. The meeting will be held during the local Festival of the Arts and recreational activities will include art exhibits, a golf and tennis tournament, mini-marathon, medical auxiliary activities, and congenial relaxation.

Thursday night there will be an open dinner and get-together cocktail hour for the drug representatives and their spouses, the local medical society, and all attending physicians. Friday will consist of approximately 10 hours of scientific sessions, including an informal luncheon to be held at the Pine Mountain Lodge. Friday evening an outdoor cocktail and hors d'oeuvres reception is scheduled at one of the local physician's homes.

Saturday will include one-half day of scientific sessions with lunch again at the Pine Mountain Lodge. Other activities will be a mini-marathon and a golf tournament at the Pine Grove Country Club. Auxiliary luncheons are planned at the Chippewa Club. Saturday evening the formal dinner will be held at the Dickinson Inn Hotel with a guest keynote speaker. Sunday morning a brunch will be held at the Chippewa Club for physicians and their spouses featuring a speaker of interest to both.

Further details are available from John Michael Garrett, MD, president, Dickinson-Iron County Medical Society, Iron Mountain, 49801.

PRESIDENT'S PAGE

High tech society needs 'high touch' response

By Donald K. Crandall, MD
MSMS president

The following article is adapted from Doctor Crandall's installation address, delivered at the House of Delegates meeting April 30 in Dearborn.

According to John Naisbitt, author of an exciting new book called *Megatrends,* we are entering a time of "high tech/high touch." Society is moving from forced technology to needing a "high touch" response for every new technological advance.

The more high technology we put in our hospitals, the less we as society are being born there, dying there; and we are avoiding them in between.

Physicians of the '80s must be able to assimilate the technological advances of our rapidly growing field and apply them with more understanding and concern for our patients. We must learn to balance the material wonders of technology with the spiritual demands of our human nature.

We will be the buffer between technology and patient.

Decentralization

Our society also is moving toward decentralization. The physician has been the center of medical care for some time. The government tried to replace us with the HSAs, without success.

Society is now demanding that the individual patient be the center of treatment. The patient will be more concerned with self-help programs, will look to supplemented treatment like hospice and well clinics, and will choose from a variety of delivery systems for medical care. There will be numerous medical and para-medical personnel competing for a share of this total care of the patient.

We must be prepared to function in this new arena of decentralization, and at the same time protect the interest and well-being of our patients.

In the 1960s, the delivery of medical care was based on medical needs. With the advent of more social awareness in the 1970s the delivery of medical care was expanded to include not only medical needs, but social needs as well. The growth and expansion of the Medicare and Medicaid programs are a reaction to this increased awareness of social need.

But in the process we have placed a significant financial burden on our state and federal governments. This is a burden they have elected not to carry, but to pass on to the hospitals and physicians of the country.

Now others, stimulated by the success of government in shifting the cost of their programs, also are shifting a portion of their costs to a smaller and smaller segment of our society.

We must decide if we will return to community risk sharing with a commitment by all to the welfare of the needy; or continue our move to preselection, cost shifting and smaller risk sharing groups.

I think our system will work only if each carries a fair share.

Legislation

With limited resources available for health care in the '80s, we will see economic factors playing a most significant role in the delivery of health care. Health care may be denied to those in need because of cost.

In the '90s, we may see an attempt to legislate bioethics and use that as a means of limiting health care to the old and needy. Once again, the double-standard of health care delivery we tried so hard to eliminate in the '60s threatens to return in the near future.

TEFRA, DRGs, and RCEs (Reasonable Compensation Equivalents), innovation, marketing internal and external environment, supply and demand; these will be the new terms of the voyage we are about to undertake. It will be important that we all understand these terms to function well.

TEFRA, the Tax Equity and Fiscal Responsibility Act of 1982, is probably the most important piece of legislation affecting medicine since the enactment of Medicare in 1965. It is an attempt to legislate the definition of medical practice and to limit reimbursement for physician services

Continued on page 406

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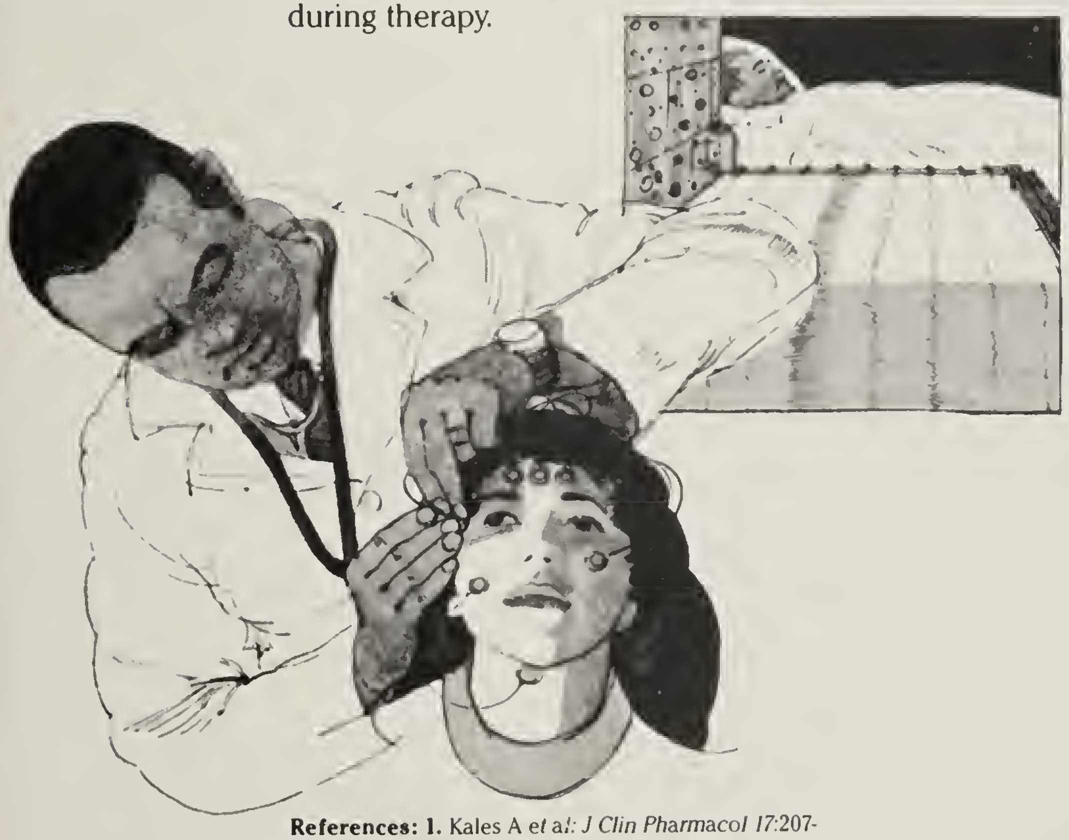
15-mg/30-mg capsules

- Studied extensively in the sleep laboratory—the most valid environment for measuring hypnotic efficacy.[1-12]
- Studied in over 200 clinical trials involving over 10,000 patients.[13]
- During long-term therapy, which is seldom required, periodic blood, kidney and liver function tests should be performed.
- Contraindicated in patients who are pregnant or hypersensitive to flurazepam.
- Caution patients about drinking alcohol, driving or operating hazardous machinery during therapy.



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Dalmane® Ⓒⅳ
(flurazepam HCl/Roche)

Before prescribing, please consult complete product information, a summary of which follows:

Indications: Effective in all types of insomnia characterized by difficulty in falling asleep, frequent nocturnal awakenings and/or early morning awakening; in patients with recurring insomnia or poor sleeping habits; in acute or chronic medical situations requiring restful sleep. Objective sleep laboratory data have shown effectiveness for at least 28 consecutive nights of administration. Since insomnia is often transient and intermittent, prolonged administration is generally not necessary or recommended. Repeated therapy should only be undertaken with appropriate patient evaluation.

Contraindications: Known hypersensitivity to flurazepam HCl; pregnancy. Benzodiazepines may cause fetal damage when administered during pregnancy. Several studies suggest an increased risk of congenital malformations associated with benzodiazepine use during the first trimester. Warn patients of the potential risks to the fetus should the possibility of becoming pregnant exist while receiving flurazepam. Instruct patient to discontinue drug prior to becoming pregnant. Consider the possibility of pregnancy prior to instituting therapy.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. An additive effect may occur if alcohol is consumed the day following use for nighttime sedation. This potential may exist for several days following discontinuation. Caution against hazardous occupations requiring complete mental alertness (*e.g.*, operating machinery, driving). Potential impairment of performance of such activities may occur the day following ingestion. Not recommended for use in persons under 15 years of age. Though physical and psychological dependence have not been reported on recommended doses, abrupt discontinuation should be avoided with gradual tapering of dosage for those patients on medication for a prolonged period of time. Use caution in administering to addiction-prone individuals or those who might increase dosage.

Precautions: In elderly and debilitated patients, it is recommended that the dosage be limited to 15 mg to reduce risk of oversedation, dizziness, confusion and/or ataxia. Consider potential additive effects with other hypnotics or CNS depressants. Employ usual precautions in severely depressed patients, or in those with latent depression or suicidal tendencies, or in those with impaired renal or hepatic function.

Adverse Reactions: Dizziness, drowsiness, lightheadedness, staggering, ataxia and falling have occurred, particularly in elderly or debilitated patients. Severe sedation, lethargy, disorientation and coma, probably indicative of drug intolerance or overdosage, have been reported. Also reported: headache, heartburn, upset stomach, nausea, vomiting, diarrhea, constipation, GI pain, nervousness, talkativeness, apprehension, irritability, weakness, palpitations, chest pains, body and joint pains and GU complaints. There have also been rare occurrences of leukopenia, granulocytopenia, sweating, flushes, difficulty in focusing, blurred vision, burning eyes, faintness, hypotension, shortness of breath, pruritus, skin rash, dry mouth, bitter taste, excessive salivation, anorexia, euphoria, depression, slurred speech, confusion, restlessness, hallucinations, and elevated SGOT, SGPT, total and direct bilirubins, and alkaline phosphatase; and paradoxical reactions, *e.g.*, excitement, stimulation and hyperactivity.

Dosage: Individualize for maximum beneficial effect. *Adults:* 30 mg usual dosage; 15 mg may suffice in some patients. *Elderly or debilitated patients:* 15 mg recommended initially until response is determined.

Supplied: Capsules containing 15 mg or 30 mg flurazepam HCl.

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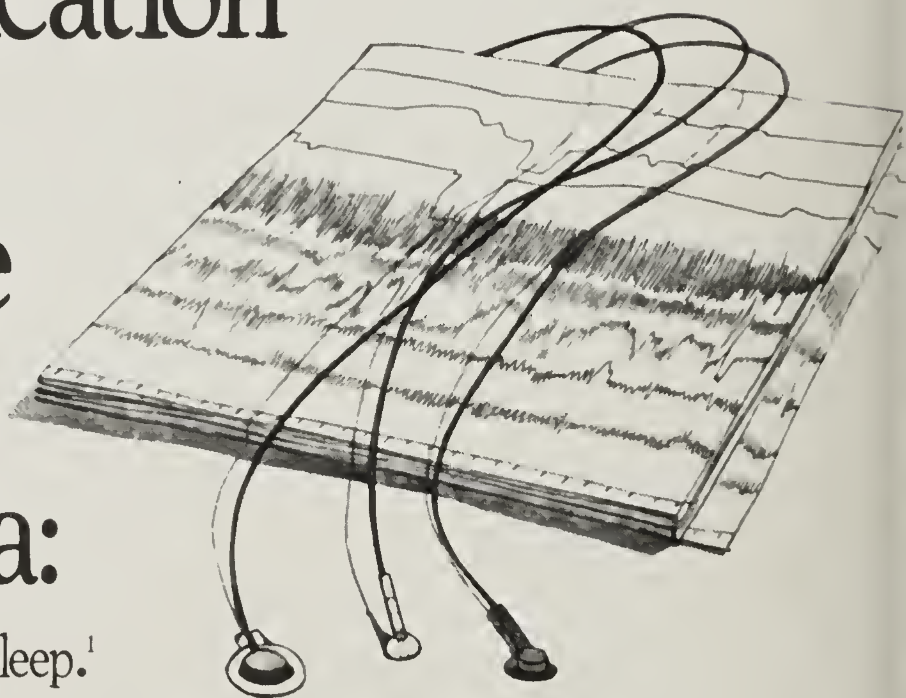

- Rapid onset of sleep.[1]
- More total sleep time on the first 3 nights of therapy.[1]
- More total sleep time on nights 12 to 14 of therapy.[1]
- Continued efficacy for at least 28 nights.[2]
- Seldom produces morning hangover.[3]
- Avoids rebound insomnia when therapy is discontinued.[1,4,5]

15-mg/30-mg capsules

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Please see summary of product information on reverse side.

Vol. 82, No. 30 June 16, 1983
Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

BIG MICHIGAN GROUP ATTENDS FIRST AMA MEDICAL STAFF MEETING

Over 40 Michigan physicians were traveling to Chicago as this was written to attend the first session of the AMA Medical Staff Section June 17 and 18. The Michigan MDs, representing the same number of Michigan hospitals, were to be guests at a business meeting/reception Thursday, June 16, sponsored by the Michigan delegation to the AMA. Hosts were Henry M. Domzalski, MD, Detroit, member, Steering Committee, AMA Hospital Medical Staff Section; Gary D. Maynard, MD, Kalamazoo, chairman, MSMS Medical Staff Relations Committee; and Richard J. McMurray, MD, chairman, Michigan Delegation to the AMA. MSMS President Donald K. Crandall, MD, Muskegon, was to address the group at the business meeting. In addition, Peter A. Duhamel, MD, Rochester, was to serve as chairman of the new AMA section's reference committee.

SOCIAL SERVICES 1983-84 BUDGET IN COMMITTEE

The Michigan legislature is driving to conclude its work before its summer recess begins just prior to the July 4 holiday. To meet that deadline, the legislators are concentrating on state budget items and giving other less critical issues lower priority. Holding them up now are 1983-84 budgets for departments of social services and education. The social services budget has moved from its subcommittee into the full House Appropriations Committee for consideration. MSMS sources report the Medicaid budget is pretty well determined, with \$1.453 billion provided for payment of medical services by the state program.

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In other legislative areas, Charles C. Vincent, MD, Detroit, was scheduled to testify June 15 at the weekly meeting of the Special House Task Force on Health Care Costs. The committee was to examine the impact of malpractice cases and insurance premiums upon costs. Doctor Vincent is a member of the MSMS Committee on State Legislation and Regulations.

REMINDER: NOMINEES SOUGHT BY MSMS FOR STATE BOARD

MSMS is seeking interested physicians who would like to serve on the Michigan Board of Medicine. The terms of three board members expire this year and those members are ineligible for reappointment. They include current board Chairman Donald Kuiper, MD. A fourth member whose term is over is eligible for reappointment. MSMS members who would like to serve on the board should send biographies to Kevin Kelly, MSMS headquarters.

MSMS OFFERS "BUCKLE UP" BUTTONS, POSTERS

"Love life! Buckle up. Your doctor cares." That's the message of brightly colored buttons, bumper stickers and posters available from MSMS headquarters promoting automobile seat belt use. MSMS has distributed 10,000 of the buttons and bumper stickers and sent every member a poster through the April issue of *Michigan Medicine*. The buttons are available for \$27 per 100, while the bumper stickers cost \$1.50 per 100, or \$2 for 200. You may order them through Mert Scholten at MSMS headquarters.

LEGAL COSTS HALT PRODUCTION OF BENDECTIN

Merrell Dow Pharmaceuticals, Inc., has ceased production of Bendectin in the U.S., the only drug approved in this country for relief of nausea and vomiting during pregnancy. According to a Michigan spokesman, Merrell Dow has ceased production because of the high legal costs of defending the drug's safe use. In a mailgram to MSMS headquarters the company president alerted physicians that pregnant women currently taking the drug "should not be alarmed by our action which is based solely on non-medical factors." If patients need reassurance they can continue their therapy with the drug with confidence, they should consult their physicians, he continued. The company is following a three-part program regarding Bendectin: 1) Advising physicians and pharmacists that patients now taking Bendectin can complete their therapy; 2) Advising customers that Merrell Dow will offer a program for handling unused stocks of Bendectin, and 3) answering all physician and pharmacist questions via a toll-free information number (800/543-1970). Michigan Medicine will carry a letter from the company in a coming issue.

MEASLES ALERT FROM MDPH

Outbreaks of measles in other states represent a potential for spread to Michigan, cautions the Michigan Department of Public Health. Though Michigan has been measles-free for several months, the MDPH recommends that measles vaccine (not measles/mumps/rubella) be given to migrant infants between six and 12 months of age and that they later (after 15 months of age) be reimmunized for measles with MMR vaccines. The use of immune serum globulin as a prophylactic is an acceptable alternative among these infants, says the department. Migrant children over 12 months of age should be promptly immunized unless a specific contraindication exists. The MPDH urging comes following sustained measles transmission in the Everglades area of Florida since late winter. An estimated 37 percent of Michigan's migrant workers come from Florida.

A small outbreak of measles has occurred along the southwestern border of Michigan; the MDPH suggests active surveillance there.

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Vol. 82, No. 30 June 16, 1983

Vol. 82, No. 31 June 23, 1983
Breaking News for Michigan Doctors
MICHIGAN MEDICINE MEDIGRAM

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CHILD ABUSE COMMITTEE MEMBERS SEEK MORE WORKERS

Thanks partly to MSMS testimony for the need, the Department of Social Services 1983-84 proposed budget includes funds for 100 more protective services workers to handle child abuse cases. The proposed budget has passed appropriations committees in both houses of the legislature. MSMS sources expect the support for increased numbers of child abuse workers will survive the remaining negotiations. Numbers of those workers have been cut during recent years as the state's budget shrank. Testifying for MSMS before the appropriations committees were Barbara Meyers Lucas, MD, Detroit, and Douglas Sargent, MD, Grosse Pointe Farms, both members of the new MSMS Committee on Child Abuse and Neglect. Doctor Lucas, a pediatrician, is director, Child Abuse and Neglect Prevention Program, Mt. Carmel Mercy Hospital, and Doctor Sargent, a psychiatrist, chairs the AMA's Committee on Child Abuse.

NO TUITION HIKE IN FINAL VERSION OF STATE HEALTH PLAN

The final version of the 1983-87 State Health Plan is going to the legislature and governor without any proposal to raise Michigan medical schools' tuition. An increase was part of earlier proposals and was intended to fund programs to improve physician distribution. In keeping with MSMS House of Delegates Resolution 30-83A, MSMS testified against the tuition increase. It was joined in this stand by several medical students. The Statewide Health Coordinating Council (SHCC) June 16-17 eliminated the tuition increase when it made several amendments to the proposed State Health Plan. The SHCC has approved the present version; if the legislature and governor agree, the plan will become the principal state guide for the development of health programs and for the allocation of health resources.

PLAN AHEAD FOR MSMS MEETINGS

Here's your chance to plan well in advance of major MSMS meetings. Mark your calendar today with these important MSMS dates:

Public Affairs/Leadership Conference	
Oct. 26-27, 1983	Long's of Lansing

Annual Scientific Meeting	
Nov. 15-17, 1983	Hyatt Regency Dearborn
Nov. 13-15, 1984	" " "
Nov. 12-14, 1985	" " "
Nov. 11-13, 1986	" " "
Nov. 10-12, 1987	" " "

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House of Delegates Annual Meeting	
May 4-6, 1984	Amway Grand Plaza, Grand Rapids
April 26-28, 1985	Michigan Inn, Southfield
May 2-4, 1986	Hyatt Regency Dearborn

Vol. 82, No. 32 June 30, 1983
Breaking News for Michigan Doctors

MICHIGAN MEDICINE MEDIGRAM

OCTORS COURY, RANDALL ELECTED O HIGH AMA POSTS

John J. Coury, MD, Port Huron surgeon, became the highest ranking Michigan physician in the history of the American Medical Association when he was elected chairman of the AMA Board of Trustees June 24. (The highest ranking Michigan physician previously was George W. Slagle, MD, Battle Creek, who served as AMA vice president.) Doctor Coury was elected chairman at the Board reorganization meeting following the annual meeting of the AMA House of Delegates in Chicago. Joseph F. Boyle, MD, Los Angeles internist who had served two years as chairman of the board, was chosen president-elect. Frank J. Jirka, MD, of Barrington Hills, Ill., succeeded to the presidency.

MSMS President Donald K. Crandall, MD, Muskegon general surgeon, also brought victory to the new 22-member Michigan delegation when he was elected to the AMA Council on Medical Service. That Council deals with the socio-economics of medical practice, and has extensive interchange with the national Blue Cross/Blue Shield Association. Doctor Crandall was chosen from among six candidates for two slots on the council.

The Michigan delegation,, chaired by Richard J. McMurray, MD, Flint, with Frank B. Walker II, MD, Detroit, as co-chair, played a highly visible role throughout the week, beginning Friday, June 17, with the organization of the first Medical Staff Section of the AMA. Henry Domzalski, MD, Detroit, was chosen secretary of the new section, while Peter Duhamel, MD, Rochester, served as a reference committee chairman.

The AMA delegates amended Michigan's resolution calling for strict oversight of clerkships for American nationals who graduate from foreign medical schools. The resolution now calls on the American Hospital Association to alert its members to the AMA position of 1982, which precisely echoes the Michigan stand. The most hotly debated issue before the House, that of the Joint Commission on Accreditation of Hospitals' revision of standards, placed the AMA squarely in defense of the medical staff model for hospital staff credentialing and quality assurance. But the House concurred with AMA commissioners on the JCAH that there is a role in hospital governance for limited licensees. Only MDs and DOs have unlimited licenses. The House also called for wide dissemination of the final JCAH paper before it is officially endorsed by the AMA.

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BCBSM AMBULATORY SURGERY PROGRAM IN EFFECT JULY 1

MSMS has just received notice from Blue Cross Blue Shield of Michigan that the two-part BCBSM ambulatory surgery cost containment initiative is in effect as of July 1. The plan has two parts, labeled the "hospital disallowance" and "least cost setting" segments. Details are available from MSMS.

1983 Annual Scientific Meeting courses inside!

Physicians attending 1983 MSMS Annual Scientific Meeting may plan now from this list of 55 courses.

Half-day courses will be for 3 hours of Category I credit. For more information, please contact Sherry Fent at MSMS headquarters, 517/337-1351.

Tuesday Morning
November 15 (8:30 to Noon)

- **"Basic Cardiac Life Support."** Director: Robert K. Orr, DO, Lansing. Sponsored by Michigan Chapter, American College of Emergency Physicians.

- **"Cancer Patient Management in the 1980's: The Role of Radiation Oncology."** Director: Harold Perry, MD, Detroit. Sponsored by Michigan Society of Therapeutic Radiologists.

- **"Child Abuse: How to Make the System Work for Your Patient."** Co-Directors: Brooker L. Masters, MD, Fremont, and Barbara Meyer Lucas, MD, Detroit. Sponsored by MSMS Committee on Child Abuse/Neglect.

- **"Diabetes — Current Management and New Developments."** Director: Dorothy M. Kahkonen, MD, Detroit. Sponsored by Division of Metabolic Diseases, Henry Ford Hospital.

- **"Emergency Psychiatry for the Non-Psychiatrist."** Director: Beverly J. Fauman, MD, Detroit. Sponsored by Michigan Psychiatric Society.

- **"Evaluation and Management of Infertile Couples."** Kamran S. Moghissi, MD, Detroit. Sponsored by Wayne State University-Hutzel Hospital and C. S. Mott Center for Human Growth and Development.

- **"Flow Cytometry: Clinical Application."** Director: Bertram Schnitzer, MD, Ann Arbor. Sponsored by Department of Pathology, University of Michigan Medical School.

- **"Helping the Troubled Employee: The Role of Physicians and Industry."** Director: Jack E. Benkert, MD, Flint. Sponsored by Michigan Occupational Medical Association.

- **"Medically-Related Communications Disorders: The Physician's Role."** Co-Directors: Myron M. LaBan, MD, and Michael I. Rolnick, PhD, Royal Oak. Sponsored by Speech and Language Pathology Department, William Beaumont Hospital.

- **"Traumatic Injuries to the Head, Spine, and Peripheral Nerves."** Director: Robert E.M. Ho, MD, Troy. Sponsored by Department of Neurosurgery, Wayne State University School of Medicine.

Tuesday Afternoon
November 15 (1:30 to 5:00)

- **"Adding Life to Years: Meeting the Needs of the Aged."** Director: William T. Bateman, MD, Kalamazoo. Sponsored by MSMS Committee on Aging and Michigan Health Council.

- **"An Overview of the Human Health Effects of Nuclear Weapons."** Director: Eugene V. D. Perrin, MD, Detroit, Sponsored by Physicians for Social Responsibility.

- **"Chronic Drug Therapy and the Surgical Patient."** Director: Gaylord D. Alexander, MD, Detroit. Sponsored by Michigan Society of Anesthesiologists and Department of Anesthesiology, Wayne State University School of Medicine.

- **"Diagnosis and Management of Pelvic Pain."** Director: John L. LaFerla, MD, Ann Arbor. Sponsored by Department of Obstetrics and Gynecology, University of Michigan Medical School and Michigan Section, American College of Obstetricians and Gynecologists.

- **"High Quality Care With DRG's."** Director: David R. Rovner, MD, East Lansing. Sponsored by MSMS Planning Committee for Annual Scientific Meeting.

- **"Medical Genetics for the Practicing Physician."** Director: Thomas D. Gelehrter, MD, Ann Arbor. Sponsored by Department of Internal Medicine and Human Genetics, University of Michigan Medical School.

- **"Medical Management of Acute Alcohol and Sedative Hypnotic Withdrawal."** Director: Russell F. Smith, MD, Brighton. Sponsored by MSMS Program to Assist Impaired Physicians.

- **"Pediatric Immunology/Infectious Diseases: New Concepts and Treatment Modalities."** Director: Dennis L. Murray, MD, East Lansing. Sponsored by Department of Pediatrics and Human Development, Michigan State University College of Human Medicine.

- **"Some Burning Issues in Gastroenterology."** Director: David S. Greenbaum, MD, East Lansing. Sponsored by Michigan State University College of Human Medicine.

Wednesday Morning
November 16 (8:30 to Noon)

- **"A Comprehensive Review of Anorexia Nervosa."** Director: Elliot D. Luby, MD, Detroit. Sponsored by Department of Psychiatry, Harper-Grace Hospitals, Wayne State University School of Medicine.

- **"Arm Pain and Dysfunction: Diagnosis and Management."** Director: Joseph C. Honet, MD, Detroit. Sponsored by Departments of Rehabilitation Medicine and Internal Medicine, Sinai Hospital of Detroit.

- **"Basic Cardiac Life Support."** Director: Robert K. Orr, DO, Lansing. Sponsored by Michigan Chapter, American College of Emergency Physicians.

- **"Esophageal Disorders for the General Physician."** Director: Joe D. Morris, MD, Ann Arbor. Sponsored by Michigan Society of Thoracic Surgeons.

- **"Evaluation and Treatment of the Dizzy Patient."** Director: Sean B. Peppard, MD, Detroit. Sponsored by Department of Otolaryngology, Wayne State University School of Medicine.

- **"Identification and Treatment of Substance-Abusing Women."** Director: Suzanne R. Parker, MD, West Bloomfield. Sponsored by Department of Substance Abuse, Henry Ford Hospital-Maple Grove.
- **"Marijuana — Its Medical, Legal, and Social Implications."** Director: George L. Royer, Jr., MD, Kalamazoo. Sponsored by MSMS Section on Clinical Pharmacology & Therapeutics.
- **"New Developments and Old Myths About Hyperbaric Oxygen Therapy."** Director: Geoffrey R. Grambau, MD, Kalamazoo. Sponsored by Michigan Chapter, American College of Chest Physicians.
- **"Surgery for the Morbidly Obese."** Director: Robert D. Allaben, MD, Detroit. Sponsored by Michigan Chapter, American College of Surgeons.

Wednesday Afternoon
November 16 (1:30 to 5:00)

- **"Allergy Update."** Director: Clyde R. Flory, Jr., MD, Lansing. Sponsored by Michigan Allergy Society.
- **"Current Management of Kidney Stone Disease."** Director: Joseph C. Cerny, MD, Detroit. Sponsored by Michigan Branch, American Urological Association.
- **"Ethical Issues in Ambulatory Care."** Director: Andrew D. Hunt, MD, East Lansing. Sponsored by Medical Humanities Program, Michigan State University College of Human Medicine.
- **"Neurological Emergencies — An Approach."** Director: Gregory L. Henry, MD, Ann Arbor. Sponsored by Michigan Chapter, American College of Emergency Physicians.
- **"Pediatric Orthopaedics for Family Practitioners."** Director: Jerome A. Conrad, MD, Big Rapids. Sponsored by Michigan Orthopaedic Society.
- **"Pediatric Otolaryngology."** Director: Bennie B. Gilmore, Jr., MD, Detroit. Sponsored by Michigan Otolaryngological Society.
- **"Recent Advances in Neurology."** Director: Raymond B. Bauer, MD, Detroit. Sponsored by Michigan Neurological Association.
- **"The Adolescent Who Doesn't Finish Any Task: Relationship to Psychosis, Depression and Drug Abuse."** Director: Sander J. Breiner, MD, Birmingham. Sponsored by Michigan Psychiatric Society.
- **"What's New in the Management of Cutaneous Tumors."** Director: Neil A. Swanson, MD, Ann Arbor. Sponsored by Michigan Dermatological Society.

Thursday Morning
November 17 (8:30 to Noon)

- **"Basic Cardiac Life Support."** Director: Robert K. Orr, DO, Lansing. Sponsored by Michigan Chapter, American College of Emergency Physicians.
- **"Controversies and Advances in Trauma."** Director: Robert F. Wilson, MD, Detroit. Sponsored by Department of Surgery, Wayne State University School of Medicine.
- **"Gastrointestinal Scintigraphy (Imaging)."** Director: Conrad E. Nagle, MD, Troy. Sponsored by Michigan College of Nuclear Medicine Physicians.
- **"Home Health Care for Infants and Children."** Director: John V. Hartline, MD, Kalamazoo. Sponsored by MSMS Committee on Home Health Care and Department of Pediatrics, Bronson Methodist Hospital.
- **"Hypertension — Current Therapeutic Update."** Director: George L. Royer, Jr., MD, Kalamazoo. Sponsored by MSMS Section on Clinical Pharmacology & Therapeutics.
- **"Medical Use of Lasers."** Director: Eugene Rontal, MD, Detroit. Sponsored by Section of Otolaryngology, Sinai Hospital of Detroit.
- **"Recent Advances in Pediatric Hematology."** Director: Laurence A. Boxer, MD, Ann Arbor. Sponsored by Department of Pediatrics, Mott Children's Hospital, University of Michigan Medical School.
- **"Scar Control."** Director: Donald M. Ditmars, Jr., MD, Detroit. Sponsored by Michigan Academy of Plastic Surgeons.
- **"Vision."** Director: Frederick W. Bryant, MD, Royal Oak. Sponsored by Michigan Ophthalmological Society.

Thursday Afternoon
November 17 (1:30 to 5:00)

- **"Common Gastrointestinal Problems in Children: Diagnosis and Management."** Director: William J. Byrne, MD, Ann Arbor. Sponsored by Department of Gastroenterology, University of Michigan Medical School.
- **"Conservative Treatment of Low Back Pain."** Director: R. Larry Joynt, MD, Detroit. Sponsored by Michigan Academy of Physical Medicine and Rehabilitation.
- **"Diagnostic and Therapeutic Interventional Radiology."** Director: Robert L. Bree, MD, Royal Oak. Sponsored by Michigan Radiological Society.
- **Ophthalmic Outpatient Procedures."** Director: Frederick W. Bryant, MD, Royal Oak. Sponsored by Michigan Ophthalmological Society.
- **"Selected Topics in Pediatric Ambulatory Medicine."** Director: Robert C. Kelsch, MD, Ann Arbor. Sponsored by Department of Pediatrics, University of Michigan Medical School.
- **Treatment of Arthritis."** Director: Joseph J. Weiss, MD, Livonia. Sponsored by Michigan Rheumatism Society.
- **"Unique Techniques in Plastic Surgery."** Director: Donald M. Ditmars, Jr., MD, Detroit. Sponsored by Michigan Academy of Plastic Surgeons.
- **"Update on Common Anorectal Problems."** Director: W. Patrick Mazier, MD, Grand Rapids. Sponsored by Michigan Society of Colon & Rectal Surgeons.
- **"What's New in Dermatology."** Director: Neil A. Swanson, MD, Ann Arbor. Sponsored by Michigan Dermatological Society.

1983
MSMS ANNUAL
SCIENTIFIC MEETING
November 15-16-17, 1983
Hyatt Regency Dearborn

MSMS PART OF NEW MEDICAID TASK FORCE

Allen F. Turcke, MD, Flint, chairman of the MSMS Medicaid Liaison Committee, is the MSMS representative on the new Medicaid Task Force established by the director of the Department of Social Services. DSS Director Agnes M. Mansour, PhD, has invited 26 concerned agencies and institutions to send representatives to the new task force, which will meet for the first time July 13. The purpose is to review the costs, benefit structures, utilization and reimbursement policies of the Medicaid program, and to recommend changes in program policies. The task force is chaired by Andrew D. Hunt, MD, dean emeritus of the MSU College of Human Medicine. Doctor Mansour is asking the task force to complete its work before the end of 1983, so that its recommenmendations can be useful in fiscal years 1983-84 and 1984-85. Doctor Turcke will serve in a subgroup on ambulatory care services, one of two divisions of the full task force.

CAPSULES

MSMS President Donald K. Crandall, MD, spoke June 29 at "Senior Action '83: Curbing Health Care Costs," a Lansing conference planned by the Michigan Office of Services to the Aging. Doctor Crandall discussed "Making Physicians More Cost Conscious" . . . . The Southeastern Michigan Program for Affordable Health Care recently learned that a site visit team is prepared to recommend funding for the program at its July meeting. The program applied for grant funds to the Robert Wood Johnson Foundation to focus on reducing and redirecting the demand for and use of services in the Detroit area . . . . CORRECTION: Date for the annual MSMS Public Affairs/Leadership Conference this year is Oct. 26, not Oct. 26-27, as previously reported in Medigram. The popular event is scheduled at Long's of Lansing conference center. . . . MSMS expects a preliminary report momentarily from the House of Representatives Special Ad Hoc Committee on Health Care Cost Containment. The committee, chaired by Rep. Matthew McNeely, has completed its fact-gathering activities, which included testimony on specific issues such as PPOs, HMOs, physician supply and hospital costs. Among those testifying were MSMS president Donald K. Crandall, MD, and Dennis Paradis, MSMS staff assigned to physician population, education and medical school enrollments. A final report, including legislative recommendations, is due from the committee in the fall.

MEDIGRAM

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